

An Exploration of Mental Health Constructions and
Children's Evaluation of a Local Authority's TaMHS
Therapeutic Resource

**A thesis completed in partial fulfilment towards the Doctorate of
Educational and Child Psychology (D.Ed.Ch.Psy)**

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Abstract

Recent government policies and initiatives such as 'Extended Schools', Social and Emotional Aspects of Learning (SEAL) and Every Child Matters (ECM) are a recognition that schools play a wider role beyond their traditional ones as citadels of learning. Within this new paradigm is an understanding that children and young people's education may be adversely affected by their emotional well-being which in turn translates as mental ill health. The importance of children's mental health in schools cannot be over-emphasised and this importance is evidenced by a government initiative - Targeted Mental Health in Schools (TaMHS) which enables children and young people to access mental health services in schools. This thesis explores and critiques the notion that mental health is a social construction and argues that the constructions that teachers and parents have of mental health goes a long way in determining which children are referred to and access TaMHS therapeutic interventions. This thesis adopts a qualitative approach and more specifically, the use of thematic analysis as a method of exploring mental health constructions held by relevant teaching staff, the parents of the children interviewed and the children themselves. The analysis also revealed that regardless of the TaMHS therapeutic intervention used, the therapies were viewed as having a positive effect on the children as a whole and there was a keen desire that the programme continues in light of the benefits garnered by the recipients of the therapies, that is, the children. The thesis highlights the importance of the voice of the child within educational and mental health paradigms by giving them the opportunity, through semi-structured interviews, to talk about their experiences of poor emotional well-being. The local authority where the TaMHS project was located had therapies that were delivered by qualified and trainee therapists specialising in

art, play, drama therapies, counselling and reflexology; Educational Psychologists (EPs) were not involved in the delivery of therapies. This thesis argues that because EPs work extensively with children and young people in schools using a number of psychometric, evaluative and therapeutic interventions, they should therefore have a more prominent role in the delivery of therapies but for this to become a reality then the ways in which EPs are trained may have to be reviewed again. This thesis concludes by further examining the role of the EP within mental health structures and suggests ways in which the role of the EP can become more prominent within such structures.

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Chapter 1

1 The Introduction

1.1 Background and Context

This thesis sets out to explore the views, perspectives and constructs relating to mental health in general and more specifically mental ill health; and how it relates to Targeted Mental Health in Schools (TaMHS). TaMHS was a £60 million centrally funded project, commissioned by the Department for Children, Schools and Families that ran from 2008 to 2011. It was aimed at alleviating the incidence of poor emotional health and well-being in children and young people. TaMHS interventions were wholly therapeutic, that is, no pharmacology interventions were used with children who were deemed as having significant enough problems but who would benefit more from a therapeutic approach. Ideologically TaMHS was a move away from the medical model of treating ill health to one based more on the psychosocial approach in which a number of therapeutic interventions have a significant adherence to. The Mental Health Foundation (MH, 2007) supports the use of therapeutic interventions asserts that they are effective catalysts in helping people to change their lives by offering alternative ways of thinking and behaving.

Although therapeutic interventions were the mainstay of TaMHS, the voice of the child regarding the effectiveness of such approaches had not really been addressed in any great detail. A randomised control study of the effectiveness of TaMHS showed a statistically significant decrease in mental health difficulties in primary school children. Conversely it was shown not to be effective for secondary school children (DfE, 2011a).

This thesis delves deeper than mere statistical evaluations. It is a study which also explores the constructs that parents, teaching staff and children have of mental health and how particular children attending certain primary schools, in turn, were able to evaluate the TaMHS therapeutic interventions they accessed.

1.2 Organisation of Chapters

The introductory chapter is an overview of mental health and more specifically terminologies, models and constructs of mental health. The chapter focuses on TaMHS and how it has been accessed and appropriated within the schools in which this research took place. This chapter therefore offers an exposition and critique of TaMHS in light of a specific local authority's¹ overall mental health policy. In other words this chapter provides the framework for the overall thesis and encapsulates the main arguments regarding the provision of mental health in the primary schools studied. The chapter shows that the discourses, that is, the specialist language, associated ideas and social outcomes used to describe social phenomena (Jary and Jary, 1991) relating to mental health through time have shaped certain children's access to education and mental health services. Therefore this chapter delves deeper into the notion of mental health as a social construction and the position of children within such constructions. According to Gergen (1985) social construction is a term that illustrates how social phenomena is appropriated and understood by particular groups of people within defined social contexts.

The second chapter (the literature review) is an analytical critique of the notion of children, mental health and education, highlighted in relevant and current literature. This chapter offers a critical review of the themes highlighted within the literature rather than being just an examination of the discourses on the subject of children

¹ The research took place in a unitary authority in the south of England

and mental health. Within the review of the literature available, relevant themes will emerge and provide the foundation for a number of issues raised. It should be noted that due to the fact that TaMHS was relatively new, there was a paucity of academic literature on this topic.

The third chapter (methodology) highlights the methods I used for data collection, the analysis, and also the advantages and disadvantages of the main qualitative method employed, that is, semi-structured interviews. This chapter takes the reader through the process of searching for, and the locating of appropriate schools, the criteria for choosing the pupils, and the process of the data collection. Throughout the thesis I make the point that the main purpose of the research is to bring to the forefront the views of children, who, I argue, had been ‘constructed’ as having mental health difficulties and therefore in need of TaMHS therapeutic interventions. This chapter therefore highlights the importance of getting the methodology right in order to satisfy these intentions and to answer the research questions.

The fourth chapter focuses on the findings of the research undertaken; it highlights further, the constructions of mental health and also the pertinent environmental factors which emanate from the interviews undertaken. Within this chapter the interview responses from the participants, that is, the parents, pupils and teaching staff are analysed, coded and then discussed under particular themes.

The fifth chapter discusses the theoretical issues that emanate from the research undertaken and the links to the literature discussed in the third chapter. Primarily, this chapter offers a critique of TaMHS and suggests ways in which mental health resources for children can be developed. Using Goffman’s (1967) framework of patients in ‘Asylums’ this chapter illustrates how the “career” of children perceived

as having problems in relation to their emotional well-being is determined by the constructions of the adults about them.

This thesis concludes with a summary of the important points raised. It also offers a critique of the work done and highlights gaps in the study.

The purpose of setting out the introductory chapter in this order is to make clear to the reader how the constructs and concepts of mental health (or in other words, how mental health is understood and defined in different contexts), were conceived, its importance in searching for the relevant literature used, the methodology employed, and the findings and discussion that followed. It provides a cogent link between the first and the last chapters and in turn gives clarity to the thesis title and the research aims and questions the study addresses.

1.3 Terminology and Definitions of Mental Health

The concept of mental health² introduces a very interesting conundrum as it straddles both medical and social influences regarding the maintenance of a healthy lifestyle and the resources and application needed to address ill health. The medical model of health has long advocated bio-medical interventions in addressing ill health but as Burr (2008) points out, there is also the acceptance that psychological and social factors can influence healthy living and that psychological assessments and interventions can equally address some areas of ill health. A possible question therefore arises: Is mental health better understood by the medical or the social model of health? Such a question however has been rendered redundant because there is an acceptance in today's multi-professional ways of working that the medical and the social models do complement each other somewhat in our understanding of

² The terms mental health, emotional well-being and psychological well-being are used interchangeably throughout the thesis

health, education and social care (DoH, 2000). The real question which needs to be addressed is therefore not the age old polemic fought between two or more competing models within health but what we consider to be the meaning of the term 'mental health'. Frederickson et al (2009)³ highlight the importance of addressing and understanding the true meaning of the term in order to appreciate the discourses and perspectives that pervade this particular concept:

A range of terminology is used to talk about mental health. The term mental health itself is sometimes avoided because of its association with stigmatising ideas about mental illness. Some prefer to use terms such as psychological well-being or emotional health to describe this aspect of human experience

(Frederickson et al, 2009, p.1)

Regardless of our appropriation of the term and the way in which people use it, what cannot be denied is that it is used frequently and is present in everyday lexicon. The Mental Health Act 1983 and Child and Adolescent Mental Health Service (CAMHS) are two common appropriations of the term. Regardless of whether the term encourages stigmatisation or helps in clarifying a particular concept or process, it is first of all important to agree a common meaning and understanding of the concept. The point that is being made here is that just because the term mental health is used in everyday lexicon; it should not be assumed that every one attaches the same universal meaning to it. In fact it is because the concept is part of everyday language it is easy to forget that it assumes different meanings according to those who are using it at the time.

³ The author uses the Harvard referencing style throughout the thesis rather than APA. Harvard allows the use of the term 'et al' in the first instance without having to state all the names of authors within the main text. All the names of the authors are stated in the bibliography

Like a number of terms which are used widely, mental health, it could be argued, is a social construction and is therefore open to interpretation in relation to the purpose it is being used to serve. Its meaning changes according to the discourses put forward in support of a particular perspective be it medical, educational, psychological or social. Due to the fact that this thesis argues that the term mental health is a social construction there is an appreciation of the other paradigms and constructs that add to our understanding or critique of the term.

1.3.1 The Medical Model of Understanding Mental Health

The medical model is closely aligned to the biological model of health (Allott and Robb, 1998). This model focuses on the identification of an illness and its cure. It is therefore a model which underpins medical practice as our health system is predicated on the diagnosis and cure of illnesses. The model is most effective within acute medicine where cures for physical ailments are required. Allott and Robb (1998) explain that the strength of this model is its focus on high-tech intervention, orientation to cure and its clear locus within hospitals.

Regarding mental health/illness more specifically, Gerard (2010) argues that according to this model, the aetiology of mental ill health relates to the biological and chemical imbalances in the brain, for example, very high cortisol levels in the brain and/or the paucity of serotonin secreted in the central nervous system. In addition, this model stresses that mental health disorders/illness may also be the result of physical injury to the brain be it genetic or otherwise. The main thrust of the medical model, however; is not just about the ways in which mental illness/disorders are acquired, it also focuses on ways in which mental ill-health can be treated by medication in order to restore harmony to the body. Waterhouse and McGhee (2002)

postulate that the model implies that the remedies to a problem encountered, lie primarily with the experts and their knowledge of medicine and medication, that is, the medical professionals, thereby undermining self-determination and authenticity. The authors argue that by focusing primarily on biological based issues of illness, the model fails to understand or take adequate account of structural, social and cultural factors that may impinge upon a person's health. The model, they opine is predicated on the malady within a person and not on the environmental factors which are inherent within. Nutt (2007) argues further that the medical model is one based on the concept of deficit and central to our understanding of it is that it primarily focuses on what is wrong with the person. The medical model still dominates our healthcare system and is reliant on the knowledge and expertise of the professionals within it. The traditional understanding of the medical model suggests that within this paradigm, power lies firmly in the hands of those who have acquired the knowledge and expertise in treating illnesses. Oliver (1996) supports this view and adds that the patient has much less power within this paradigm. Power it is important to note is described by Giddens (1985) as being the transformational capacity inherent in people to intervene in a series of social actions with a view to altering them.

1.3.2 The Psychiatric Model of Understanding Mental Health

Closely aligned to the medical model is the psychiatric model; it understands mental health difficulties through the assessment and classification of symptoms a patient may present with. The main difference between the psychiatric model and the medical model is that the latter focuses mainly on mental illness while the former is aimed at illness in general. This psychiatric model is realised within the Diagnostic and Statistical Manual of Mental Disorder (DSM) which is used by medical and clinical professionals to pinpoint and name the actual disorder a patient presents

with. As with the medical model, the psychiatric model forms the mainstay of community mental health services within the National Health Service (NHS). Ballou and Brown (2002) state the diagnosis and treatment of mental health disorders is predicated on the rubric of mental illnesses as described within the DSM:

The DSM remains an exercise of fitting the child to the category rather than beginning with the system that is developmental in nature and takes a holistic approach in understanding and describing children's experiences and behaviours within a broad social, economic, and familial framework

(Ballou and Brown, 2002, p.263)

The central premise of this model is the positivist approach which deems that evidence based practice has to stem from randomised controlled trials and is therefore aligned more to the natural sciences thereby wholly focusing on objectivity via the observation of symptoms a patient may present with. Like the medical model, authority to diagnose mental illnesses is invested in those who have the expert knowledge and hence power to do so. Waterhouse and McGhee (2002) are of the opinion that medical knowledge alone is insufficient when working within mental health paradigms because mental ill health is sometimes more than just chemical imbalances in the brain. They argue further that even though the professionals may have expertise in the field of psychiatry, they are not always appropriately trained to deal with complex psychological processes and the socio-political contexts in which they occur.

This brings to the fore the fact that mental health/illness should not be exclusively considered within strictly psychiatric/medical paradigms as there are many social and cultural factors which may impinge upon a person's mental health. Ballou and Brown (2002) highlight the fact that this model does not take into consideration the

social context and add that within the strict diagnostic framework in which the model operates, there is an assumption of similarity, which allows professionals to adopt a utilitarian approach to dealing with mental health and psychological well-being. Caution is therefore urged when using this model. Oliver (1996) warns that adherents of this model are potentially in danger of over-medicalising and over-diagnosing natural and normal responses to everyday strains and stresses.

Boyle (2007) states that systems and parameters such as the DSM alters research by focusing wholly on the maladaptive brain as being the sole cause of mental ill health thereby not focusing enough on antecedents within a person's social environment:

Yet there is strong evidence that emotional distress and behavioural problems, even the most bizarre, are understandable responses to or ways of actively trying to manage adverse circumstances and relationships

(Boyle, 2007, p.290-291)

As with the medical model, Oliver (1996) argues that professional knowledge and expertise is considered to be of more importance in the treatment of patients, than patients' own understanding and experience of their condition. This, the author remarks, indicates an unequal power relationship between the professional and the patient within this paradigm.

1.3.3 The Psychosocial Model of Understanding Mental Health

The psychosocial model has arisen and attained due regard within mental health paradigms as a result of the dominance of the medical/psychiatric models within health, which favours wholly positivist infused evidence based approaches. In other words, it is almost a direct reaction to the dominant views, perspectives and

practices of wholly positivist approaches within health in general which protagonists like Thorton and Lucas (2011) consider to be too narrow in focus. Tew (2005) in support of the psychosocial model argues that within mental health paradigms the biomedical perspectives and discourses are still very dominant and therefore subsumes other approaches in favour of positivist led evidence based practices on which individual medical diagnoses are made.

The psychosocial model is best understood as an overarching paradigm which encompasses a myriad of approaches that emphasises the importance of understanding mental health and psychological wellbeing within an ecological context. It lends itself to Bronfenbrenner's (1979) ecological approach as a way of supporting and understanding the needs of people within a web of relationships found within social networks. The Framework for the Assessment of Children in Need and their Families (DoH, 2000) is a good example of this approach where the health and social needs of children and their families are understood by taking into account health, education, emotional and behavioural development, identity, family and social relationship, social presentation and self care skills. The significance of using a psychosocial approach is that it gives professionals the 'environmental map' of how mental ill health occurs and how support within the home and the community can help alleviate its occurrence and intensity. Within this model individuals are empowered or supported by professionals to act as a catalyst in improving their overall lifestyle including health. Within this model, professionals such as applied psychologists are encouraged to work with individuals and families and so the power differential between professional and stakeholder is reduced.

The psychosocial model is not without its limitations. As Rixon (2011) points out, the environmental perspective which is central to our understanding of the psychosocial model is not static but dynamic, chaotic and not linear. Support within this model first starts with the family even though it could be that the family is the root cause of the mental health difficulties being experienced.

1.3.4 The Legislative Model of Understanding Mental Health

The understanding, identification and delivery of services within mental health paradigms in England and Wales are codified within specific legislation such as the Mental Health Act 1983. According to the Mental Health Act 1983 (Cull and Roche, 2001), mental illness is understood as any disorder affecting the mind. This arguably leaves such a definition open to interpretation and therefore at the behest of the professionals who work within their defined statutory duties. Spender et al (2001) exemplify this when stating that both the Mental Health Act 1983 and the National Assistance Act 1948 are examples of professional statutes with a limited field of application whose interpretation and use are a matter of professional discretion.

As exemplified in the medical and psychiatric models, the authority to diagnose mental ill health is reliant on the expertise of the appropriately qualified professionals, namely doctors/psychiatrists. Under the legislative model however, if a person needs to be forcibly detained ('sectioned') under the auspices of the Mental Health Act 1983, the intervention of the Police and Approved Social Workers (ASWs), in addition to the appropriately qualified medical professionals, is also required. It should be highlighted that because Police Officers and Social Workers are not medical professionals the identification of mental illness may be based on their subjective interpretation of legislation rather than on a cogent understanding of

what a person is going through at the time. The danger therefore is that some people face the potential risk of being 'sectioned' based on non-medical professionals' construction of mental ill health rather than on strict psychiatric parameters.

It should be noted that mental health legislation such as the Mental Health Act 1983 is more relevant to adults and adolescents. Children with mental health difficulties are classified under the term 'children in need' within the Children Act 1989. Bridge et al (1992) explain that the Children Act 1989 requires local authorities to provide relevant resources in order to meet the needs of such children. The importance of the legislative model and more specifically the Children Act 1989 is the fact that children with mental health difficulties are defined within it, and through it are able to access relevant resources like CAMHS. Accessing resources like CAMHS places children within the context of mental health where they assume the role of the patient. As with adult patients, children within mental health contexts, it could be argued, have relatively very little power in relation to the professionals who work with them.

1.3.5 The Relevance of the Models of Mental Health

The models mentioned above do not represent an exhaustive list of all the constructions available. The importance of understanding the different models or constructions is that EPs and other relevant professions are expected to work within these different paradigms. How EPs engage with these models will impinge directly on how they view mental health and how it is appropriated within their service. The advent of the Children Act 2004 (and the ECM policy that emanated from it) marked a more concerted directive towards multi-disciplinary cooperation between professionals working with children. The implementation of this particular legislation

has resulted in professionals working together under different guises be it the Common Assessment Framework (CAF), Team Around the Child (TAC), Team Around the School (TAS), Core group meetings, Safeguarding Children Conferences (SCC), Child in Need (CIN) meetings and the like. The important thing to note here is that the various professionals sitting around a conference table may have different models, discourses and constructions of mental health and indeed of children. It is therefore imperative that the EP understands the discourses and constructions that exist and in order to engage effectively with these differences and so ensure that the best outcomes for children are achieved. There is also the need to understand the power dynamics operating within each construction. A psychiatrist's diagnosis of mental illness, it can be argued, will be considered to be of more relevance than a non-medical professional's understanding of mental illness. The point being stressed here is that EPs will need to have an understanding of the dynamics of power which exist within multi-disciplinary partnerships in order to make effective contributions to them. In so doing, the EPs highlight the important role they play in understanding the personal, psychological and systemic issues which impinge upon children's emotional well-being.

The issue of power cannot be over-emphasised within medical and mental health paradigms. As alluded to earlier in this section, social constructions carry within them elements of power. It could be argued that within the hierarchy of mental health, the professionals with the most influence are the medical doctors and psychiatrists due to the fact that they have the knowledge and expertise to diagnose mental ill health. Non-medical professionals like EPs may have invaluable insights and perspectives into mental health but they do not have the medical expertise to diagnose mental ill health. Within mental health/medical paradigms the medical and psychiatric models

prevail. Power however is not a static quantity. A case could be made that the EPs' input towards Statements of Special Educational Needs (such as the writing of Appendix Ds) may be considered to be of more value than the input of medical professionals especially if the requirements of the child are deemed to be non-medical. As EPs have a statutory role within this context, a legitimate point can be made which states that this legislative role gives EPs a more significant standing and hence power over other professionals. Davidson et al (2008) stress the importance of EPs within multi-disciplinary partnerships and assessments by adding that their role is one of professional collegiality and problem solving.

This multi-disciplinary role is further enhanced by the current government's re-appraisal of special needs education. In the response to the Green Paper on Special Needs Education (DfE, 2011b), EPs are encouraged to work more closely with other agencies and to focus more intently on early intervention and preventative work.

As various constructions of mental health carry within them a degree of power there is a need to highlight the power or more precisely the lack of power in relation to the recipients of mental health services. As TaMHS as a resource was aimed at children, there should be an acknowledgment of the paucity of power they possess within mental health structures. Woodhead (2008) discusses the power dynamic between children and asserts that:

Children's needs have been constructed as part of a standardised model in which childhood is a period of dependency, defined by protectionist adult – child relationships in which adults are dominant providers and children are passive consumers

(Woodhead, 2010, p.78)

This thesis attempts to redress the power imbalance by giving the children who were in receipt of TaMHS, a voice and in so doing the time and space to talk about TaMHS and how they engaged with, and evaluated the therapeutic interventions offered to them.

1.4 The Delivery of TaMHS within Schools

TaMHS as a project and resource was not overly prescriptive on how it was delivered within the various geographical areas where it had been piloted. In Norfolk, for example, the EPS were directly involved in the referral process and the delivery of therapeutic interventions. In my local authority, the EPS had more of a long arm/hands off approach. What I mean by this is that individual EPs were involved in the evaluation of the project as a whole but not in the referral of children to the resource, or the delivery of specific therapeutic interventions. Children were referred to TaMHS on the instigation of teaching staff and the approval of the relevant parents, which in turn, was based on their own subjective construction of mental ill health. As teaching staff do not necessarily possess medical/psychiatric qualifications or expertise, their 'diagnoses' of mental/emotional ill health is therefore based on their own particular constructions and models of mental health and/or their interpretation of BESD (Behaviour, Emotional and Social Difficulties) thresholds within their particular schools. This is not to say that their constructions of mental health are not valid; my argument is that their constructions may be different from other professionals especially those with medical, psychiatric and psychological expertise.

1.5 Mental Health and Stigma

The construction of mental ill health brings with it the spectre of societal exclusion. In the 19th and early 20th centuries people adjudged to have long term and severe mental ill health difficulties were institutionalised within large hospitals on the outskirts of mainstream communities (Goffman, 1963,1967). These in-patients were often cut-off from their families and the wider communities. The Community Care Act 1990 addressed the issue of social exclusion. This legislation instigated the closure of these institutions in favour of reintegrating in-patients back into their various communities (Cull and Roche, 2001). This is in line with what Thornton and Lucas (2011) refer to as the 'recovery model'. This model is predicated on the enabling of people deemed as having mental health difficulties to build meaningful lives for themselves through active support from people within their communities. This enables people to gain active control of their lives. It is based on social inclusion models which reject the pathological constructions of mental illness which signifies patients' dependency on health professionals in favour of self-determination.

Regardless of whether people were institutionalised within segregated hospitals or cared for within the community, mental ill health has always had a stigma attached to it. Bailey (2002) alludes to this point and states that in addition to stigma, children and young people have limited influence regarding the delivery of services aimed at them. The author says that mental health resources which have been planned in collaboration with young people have a greater rate of success than those planned without their input.

There is no evidence to suggest that children and young people were involved in the planning of TaMHS. The paucity of children's understanding of complex structures is

sometimes used as a reason not to involve them. In other words, the idea of children as being less able in comparison with adults is a construction that holds sway amongst a number of older people. As Woodhead (2010) points out:

After all, judgments about what is desirable for children and how to achieve it are made by parents, by teachers, by policy makers, by society – not by children themselves! Unless, that is, we are attributing to children themselves a sense of the prospect of emotional security that lies ahead, and an understanding of the kind of experiences to promote it

(Woodhead, 2010, p.68)

A main aim of this research is to involve children in the evaluation of TaMHS and by doing so highlight how important their views are within the delivery of such a resource.

1.6 The Social Construction and the Social Ecology of Mental Health

As mentioned at the beginning of the chapter, there is not a universal understanding or over-arching definition for mental health and psychological well-being. The social construction of mental health, it would appear, is influenced by a number of perspectives and discourses which in turn influences our day-to-day understanding of the term. It should be added that just because the term is used in one area or discourse, it does not necessarily mean that other perspectives/discourses will have no impact on it.

Intriguingly Burr (2008) is of the opinion that the term ‘social construction’ is in itself difficult to define and fully understand because of its multiple usage by other disciplines, notably sociology. Despite this less than exclusive ownership and application of the term, it should be emphasised that regardless of its appropriation by various people and disciplines there is still considerable value in arriving at some

sort of common ground or common understanding of 'mental health'. The World Health Organisation's (WHO) definition, for example, incorporates mental health within the general/holistic health paradigm:

Mental health is more than the mere lack of mental disorders. The positive dimension of mental health is stressed in the WHO's definition of health as contained in its constitution: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy...and recognition of the ability to realise one's intellectual and academic potential

(WHO, 2004, p.7)

The importance of realising 'one's intellectual and academic potential' can be significantly appropriated to children and young people in terms of their educational attainment. Frederickson et al (2009), in analysing the WHO's definition add that in these terms, mental health for children is not only a significant element in the realisation of academic achievement but also reflects the holistic nature of children's well-being:

Mental health is influenced by multiple and interacting social, psychological and biological factors, just like physical health. Risk factors include poverty, poor educational outcomes, lack of nurture, conflict and violence

(Frederickson et al, 2009, p.1)

The risk factors Frederickson et al (2009) refer to positions mental health and illness within the ecological paradigm. The focal point of their treatise is the fact that health in general is significantly affected by one's environment.

Prilleltensky and Nelson (2010) explain the significance of environmental factors that help shape people's overall social and emotional well-being. The authors refer to

'sites' when explaining the effects of environmental factors on the social and emotional well-being of individuals. They go on to say that there are many aspects of the psychosocial, economic, political and physical environment that influence the state of an individual's well-being. Bronfenbrenner (1979) takes the environmental paradigm further and relates the issue of social and emotional well-being more specifically to children. He adds that children exist within interdependent and interconnected matrices which consist of people, places, cultures, beliefs and other economic and social factors. The diagram below (Fig.1) illustrates how Bronfenbrenner understands the way in which children are supported (ecologically) within their own environments.

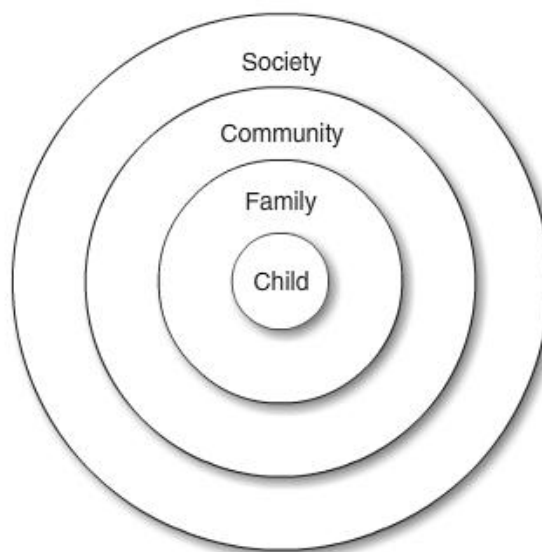


Figure 1.1 Bronfenbrenner's (1979) Ecological Model

Bronfenbrenner's model, as illustrated in the diagram above, relates more to how children are supported generally within their communities. Rose et al (2009) in support of the ecological perspective specifically relate it to the delivery of mental health resources within schools by stating that:

It is therefore important to recognise that the management of mental health in young people with special educational needs is likely to be most effective when a holistic approach is taken. Actions to ensure emotional well-being and good mental health must address not only the needs of the individual, but also those other familial and environmental factors that may have a negative impact

(Rose et al, 2009, p.3)

The National Association of Schoolmasters/Union of Women Teachers NASUWT (2005) in confirming the important role that schools play in the emotional and psychological well-being of children content that:

Schools have a crucial role to play in the delivery of mental health services, the recognition of mental health problems in children, and in the promotion of the environment that is conducive to mental wellbeing. This view is supported both by YoungMinds (1996) who argue that schools are uniquely placed to positively affect the mental health of children , and the DfES (Department of Education and Skills, 2001a), who through their National Healthy Schools Standard, state that promoting children's mental health within schools has beneficial educational impact

(NASUWT, 2005, p.11)

Invariably, however, if mental health issues are being realised and situated within schools then by default staff within schools, especially teachers will need a modicum of expertise and support in this area if they are to understand, meet or engage with pupils at their point of social and emotional need. There are structures within schools which could be said to manage these needs. Children who are deemed as having behavioural, social and emotional difficulties may have their needs met. first under School Action (that is, with the direct and general support of SENCOs, teachers and teaching assistants) or more specifically under 'School Action Plus'. Within the

paradigm of 'School Action Plus', professionals located outside the confines of the school, for example, the Behavioural Support Service (BSS), EPS or even CAMHS may engage with such children. Also there are other specialist groups that aim to support specific children with certain difficulties, for example, children with a diagnosis of an Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). These extra resources, however, do require the school staff to bring such children to their attention and this invariably assumes that teachers located within classrooms are skilled enough to observe and 'diagnose' a range of issues relating to the emotional well-being of children.

1.7 TaMHS and the Importance of Social Ecology

The premise for the setting up of TaMHS was the explicit realisation and understanding that the emotional well-being of children is not always contingent on medical or congenital factors (DCSF, 2008). In adopting such an approach there is an equal understanding that the factors which promote or adversely affect the emotional and psychological well-being of children are largely located within their immediate environments. Within the social discourse of TaMHS is the appreciation that children live within an 'ecological' paradigm of interrelated systemic factors, where the well-being of children and young people is affected by the social situation in which they reside (Bronfenbrenner, 1979). Gersch et al (2010), in explaining the social ecological/environmental context further, add that whole school effectiveness is inextricably linked with individual, social and behavioural elements, for example, how pupils behave towards each other and towards staff, how staff feel about their environment and how the school deals with non-academic problems that a child may be facing. The ecological model can be an invaluable tool in our understanding of systemic issues affecting children and this view supported by Gill and Jack (2007)

who urge practitioners to consult with children and their parents because their lives and specific experiences are embedded within the social ecological perspective.

It should be noted that even though the environmental/ecological model as proposed by Bronfenbrenner (1979) and Gill and Jack (2007) has within it underlying systemic explanations regarding how children are supported or not as the case may be, as mentioned earlier, it is by no means without its limitations. O'Dell and Leverette (2011), for example, argue that even though this perspective has a robust, practical and vocational relevance, it can only represent children and young people within a particular stage in their lives. Environments are fluid and dynamic and because of this it is necessary to consider changes in children and young people in terms of their development. This model, the authors add can also imply a deterministic view of the world in which certain events or factors predict particular behaviour or events.

Whole school initiatives such as Extended Schools, SEAL and TaMHS adopt the notion of inter-relatedness into their service delivery and within it an understanding and appreciation of the different environments, family backgrounds and social conditions children come from. What also needs to be understood is that even though a number of children from certain backgrounds may experience similar difficulties, it does not make it contingent that congruent behaviours will occur amongst them.

1.8 The TaMHS/SEAL Interface

The government report 'Social and Emotional Aspects of Learning' (DfE, 2010) adopts a psycho-educational approach to social and emotional well-being within educational paradigms. The implication of such an approach or perspective is that it emphasises the imperative of fostering personal and social competence in children

as the foundation needed before learning and emotional stability can be fully achieved. An argument to be put forward regarding this approach is that this method of intervention focuses more on the resources within the child as aspects to be developed rather than in trying to make changes within the child's immediate environment. It brings into light the age old polemic between proponents of the medical and social models of disability where the former sees disability or impairment as something that is within the person, while the latter views disability as being outside of the person but firmly within his/her environment. Hamilton (2011) asserts that mental health should not be seen as something which wholly exists within individuals but also within the contexts in which they live; this perspective is aligned more to the social model rather than the medical model of disability. It should be stressed at this point I am not bringing into the discussion the rights or wrongs of any perspective pertaining to disability or impairment but just highlighting the influence of psycho-educational approach on SEAL and in effect on TaMHS.

SEAL adopts a three-tiered targeted approach of service delivery in schools

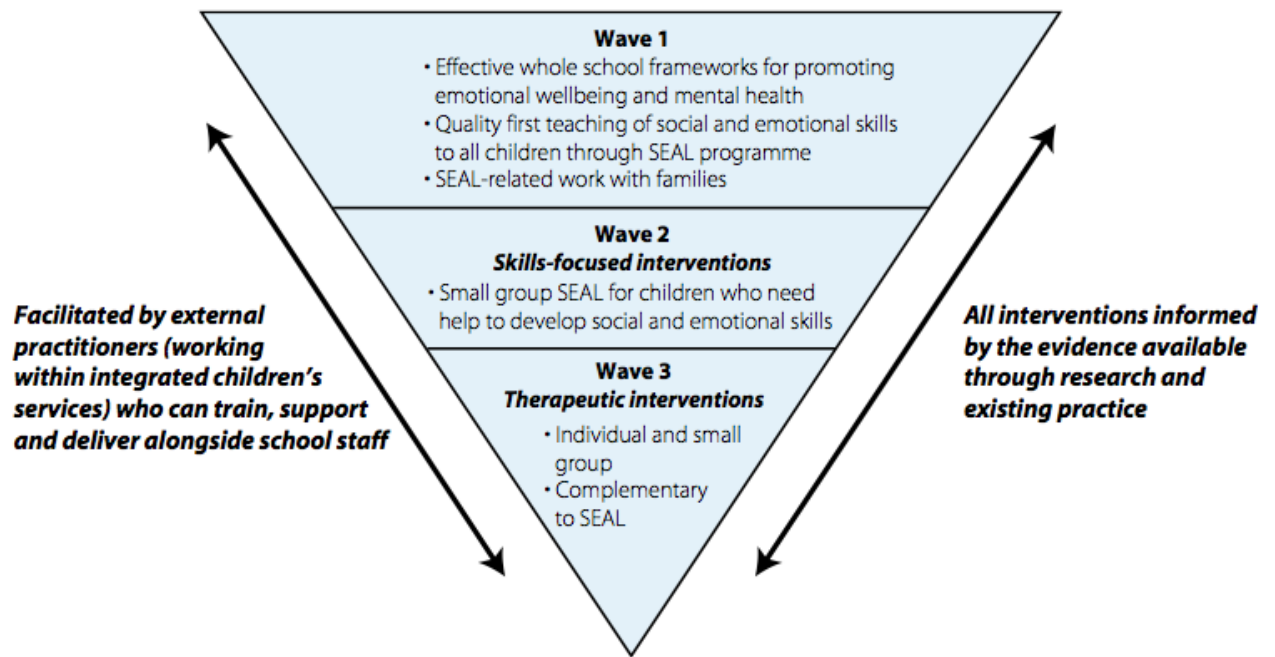


Figure 1.2 Three-Tiered Targeted Approach Model 2

As illustrated in the model above, the realisation of SEAL within schools is delivered via three waves:

- The first wave could be considered to be general service provision in which a whole-school approach is adopted. Within this wave the promotion of emotional well-being is done through existing policies and frameworks. This can normally be delivered by a teacher or teaching assistant within the classroom, school assembly hall or playground. This roughly equates to support at School Action Level
- The second wave is undertaken with children in need of additional help. This is normally delivered within small groups by specialist and trained personnel such as SENCos and TAs. Such support could be at both School Action and School Action Plus
- The third wave is a yet more focused approach where individual interventions are needed and normally carried out by professionals who are, for example,

specialist teachers and other allied professionals such as speech and language/occupational therapists. This level of support is normally carried out at the level of School Action Plus

TaMHS like SEAL brings to the fore the realisation that schools are no longer just places where children are taught. School environments are agents of socialisation for children. There is now some awareness among policy makers that even though the main purpose of compulsory education is to ensure that on leaving school, children and young people are imbued with the skills in which they need to negotiate the outside world; they also need adequate social and emotional skills. In the government publication 'Removing the Barriers to Achievement' (DfES, 2004) there is both the understanding and acceptance that if children are not emotionally secure, they are less likely to thrive within school. TaMHS fits this paradigm as highlighted in the government publication 'Learning from Targeted Mental Health in Schools Phase 1 Pathfinders' (DCSF, 2009):

The TaMHS pathfinders are tasked to build on the success of National Healthy Schools and Social and Emotional Aspects of Learning (SEAL) programmes in both primary and secondary schools...Using a whole-school approach to create the climate and conditions that implicitly promote the skills and allow these to be practised and consolidated

(DCSF, 2009, p.4)

Like SEAL, TaMHS is also based on a three-tiered approach based on a whole-school approach as seen in the figure below:

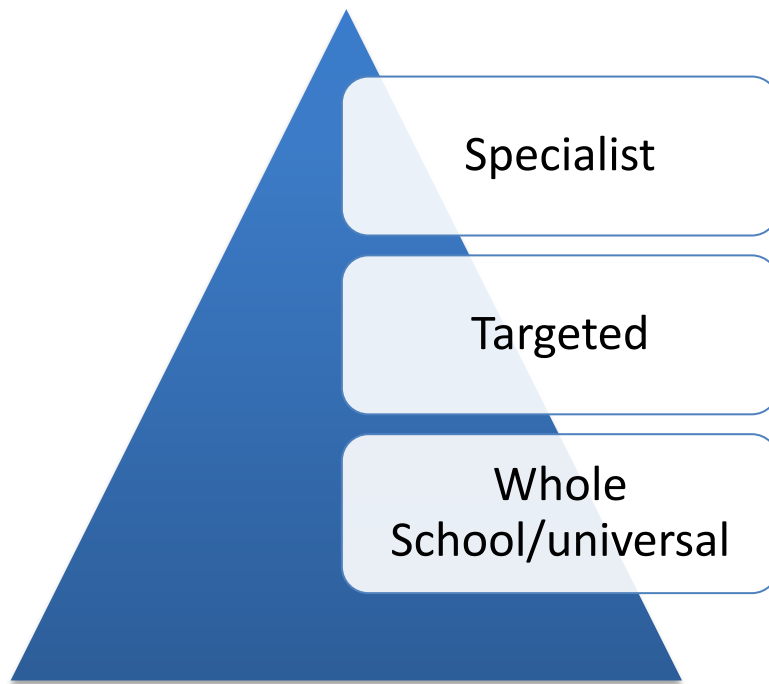


Figure 1.3 Three-Tiered TaMHS Model 3

When comparing both the TaMHS and SEAL models it does appear that they are one and the same thing but with different names. TaMHS is a specific resource based on the three-tiered SEAL policy. This is acknowledged in a TaMHS publication (DCSF, 2008, p.4):

The '3-waves' interventionist model will be familiar to schools from the national literacy and numeracy strategies. The range of interventions proposed is centred upon the Social and Emotional Aspects to Learning (SEAL) programme and is aligned with recommendations of the National Institute for Clinical Excellence on promoting social and emotional well-being

What the passage cited above seems to suggest is that there is a high level of congruity between SEAL, TaMHS, National Learning Strategy and NICE regarding the promotion and development of children's mental health within schools.

1.9 The Researcher's Position

The 'true' meaning of mental health has been discussed in an earlier section where the issue of discourses and perspectives were highlighted. The challenge in a study like this is to see how we can go beyond the existing discourses. This can be done, I argue, by acknowledging the fact that mental health/illness is not just a medical/psychological reality but is also a social construction because within TaMHS, medical professionals are not necessarily involved in the 'diagnosis' and 'treatment' of the children who are referred to this resource. The reality is that the children who accessed TaMHS in my local authority were referred to the resource by the teaching staff in their schools with agreement from their parents. If mental health/illness is not just to be considered within wholly medical/psychological paradigms then it stands to reason that mental health can and should be considered within socially constructed paradigms also. If mental health is among other things, a social construction, then it must be emphasised that such a term can therefore be constructed, re-constructed and deconstructed. This is realised by allowing the views and experiences of teachers, parents and, most importantly children, to be considered and taken seriously. A key challenge in this research therefore is to listen to what children within TaMHS are saying about their own views and experiences of the therapeutic resources they have been referred to. Although the epistemological stance which this thesis takes centres wholly on social constructionism, it should be mentioned that it also takes in the process of self-construction and evaluation. Expressed differently, the issue of one's own identity will also be a pertinent part of this process of construction.

An intriguing enquiry into human nature focuses on who we are and how others perceive us. Simply defined, this is known as identity. In psychology there are three main approaches into the study of identity. The psychosocial approach as postulated

by Erickson (1968) and Marcia (1994) view identity as fixed developmental phases. Social Identity Theory (SIT), on the other hand, attempts to portray the subject as being formed by in-groups and out-groups as highlighted by Tajfel et al (1971 cited in Phoenix, 2002) while the social constructionist approach sees identity as something fluid, not fixed and open to various perspectives and interpretations. This thesis will explore in some detail, the meaning of social construction juxtaposed against the other main theories. It will also provide a critique of social construction in order to investigate its usefulness in our understanding of identity.

Phoenix (2002) works on the premise that humans are social beings and therefore socially constructed. In other words, just as physical constructions like buildings can be altered, redesigned, renamed and rebuilt, so a person's identity is socially constructed and reconstructed. Mead (1967) adds that the 'self' which is an object in itself is essentially a social structure/construction and arises from social experience. The self is something which is realised through processes; it arises out of social, rather than just natural experience and activity. It develops in the given individual as a result of his/her relations to that process as a whole and to other individuals within that process. Mead further explains that the 'self' is made up of the 'I' and the 'me', that is, who we think we are and how other people relate to us. Invariably this means that others can also form a construction or opinion of who we are, and through that process affect our idea of self and therefore identity. Potter and Wetherell (1987) give the example of how labels and identities are socially constructed. A person may consider himself/herself a freedom fighter while another might label the same person a terrorist. Goffman (1958) locates identity within the person but argues that our identity and behaviour depends on who we are with. Using the analogy of the

theatre, he says that people behave differently when they are front stage (formal settings) than when they are backstage (informal settings) and without a script.

Rogers' (1967) personality theory states that self-concept and self-perception are fundamental components of personal identity. He proposes that because life-meaning and behaviour are essentially purposeful, individuals require freedom to make choices and create and develop their own personalities in order to construct a valid presence in the world. Of course, language is the core of this process of self-construction. Without language, the ability to narrate lived experiences is lost. The individual cannot inform the world who and what he/she is or understand who and what others are, hence is unable to find an appropriate place in the scheme of things.

Children who are regarded as having poor emotional/psychological well-being, on average, continue to achieve markedly lower academic attainments than children who are not. (Howe et al, 1999) This could be due to certain factors within the school as well as at home. Such children, especially those regarded as having behavioural and emotional problems are more likely to be excluded or have very poor attendance (Brodie, 2003). Teachers also may have a poor image of such children compounded by their poor academic attainments resulting in the appropriation of negative labels towards them thereby adversely affecting their emotional well-being even further. This is why the views of children need to be highlighted; they need time and space to relay their own views and given the chance to counter the negative constructions adults may have of them. This premise is however based on the idea that children will be confident and competent enough to express their views clearly. If they are unable to express themselves clearly then their views will need to be sought in ways

more conducive to their understanding and their most effective means of communicating.

The voice and views of children referred to TaMHS, I argue, have not been properly heard to date, but inferred by professionals who themselves are not party to their experiences. This has resulted, it could be argued, in the educational experiences of such children not being effectively understood or left unheard. Being heard, however, is a two-way process; the professionals have a duty to listen to what is being said to them but at the same time the child also needs the tools in which to air his/her experiences effectively. Collating the views of children should not be considered a mundane act of participation. Lansdown (2011) is of the opinion that actively listening to children will afford practitioners to understand better the perspectives of children and in, adapt the ways in which they work with children and in doing so, meet their needs more effectively. This often depends on children being socially literate and verbally competent. Soler et al (2009) stress the importance of literacy in children especially in relation to the inequalities that abound. They highlight a link between poor literacy and verbal skills and argue that without access to effective forms of literacy, inequalities will be difficult to overcome.

This thesis argues further that the educational discourses have constructed children with mental health issues as disruptive without acknowledging that the origins of the problems of such children face is located within their environment and not necessary within them even though difficulties within the classroom abound. Crow (2003), for example, challenges the assumption that children who present with Emotional and Behavioural Difficulties (EBD) are particularly more disruptive than any other group of children. Arguing from her perspective as a disabled person, Crow says that it is the medical model of disability that locates disruptive behaviour within an individual

without being cognisant of the fact that systemic and environmental factors that may impinge upon a child's behaviour in the classroom. Galloway et al (1994) in their research on the assessment of children with SEN focused on children with EBD and arrived at the conclusion that children who presented with emotional difficulties, and hence disruptive behaviour in the classroom usually came from difficult family backgrounds where basic childcare was found to be wanting.

Although the epistemological and theoretical basis of this research is informed by social constructionism it needs to be emphasised that for every construction there is an equal and opposite deconstruction. Social constructionism discussed in isolation is vacuous if not considered against competing deconstructions and co-constructions. When addressing social constructionism the power relationships between self autonomy (agency) and institutionalised social arrangements (structure) have to be considered at all times. This view is supported by O'Dell and Leverette (2011) who argue that the power relationships within social constructionist paradigms are open to critical examination because of the interactions between professionals, parents, children and young people.

1.10 Research Rationale

My route into educational and child psychology was not through teaching, unlike a significant number of EPs in England and Wales, but through social work where I worked in a number of Child Protection/Safeguarding Children and 'Looked After Children's' teams. A common theme between these two groups of children/young people was the fact that they were considered by their teachers to be disruptive in class and their attendance in school erratic. Another commonality between them was the fact that a significant number of them came from very unstable families and

socially/economically deprived communities. It was apparent to me at the time that the emotional strains and stresses that they had experienced would have had an adverse impact on their overall psychological well-being. The surprising thing to me at the time was the fact that at no point did I come into contact with EPs who, in my opinion, are best placed to work with such children. Working in partnership with EPs would have added depth and clarity to the work already carried out by the social workers.

Current EP training is now incorporating within it more of a focus on therapeutic approaches and working more effectively with children in systemic ways (Mackay (2006). Mackay stresses the need for EPs to become more involved in the delivery of therapeutic interventions which invariably means that the role of the EP has to be re-assessed and re-defined within current multi-disciplinary structures.

Policy initiatives like SEAL emphasise the importance of the emotional well-being of children within schools. Regardless of what relevant policies are in place, if they are to be effective, children will need to be consulted. There are clear advantages of consulting with children. It gives them a sense that their views are important and that they are a significant part of the process. In other words, it gives them a sense of worthiness and empowerment. The opportunity to take part in the feedback process should also have a positive effect on the way resources are tailored towards their needs and the manner in which professionals engage with them. There are however potential limitations that need to be taken into account when consulting with children. Not all children will have the necessary language skills or understanding in order to effectively contribute to the processes they are involved in. It should also be mentioned that the processes within education, health and social care are very likely to be adult-centred thereby limiting the potential contribution that children can make.

1.11 Research Aims

This thesis has four strands to it: (1) it explores how TaMHS was delivered in the local authority where the research took place (2) how children in the local authority were viewed, evaluated and constructed by parents/teaching staff regarding their emotional, behavioural and mental health needs (3) how these children understood their own behaviour (4) how the children evaluated the TaMHS interventions they had access to.

In other words, this thesis offers a critique and evaluation of TaMHS therapeutic interventions by the recipients of these interventions, that is, the children. In particular this thesis also addresses four research questions, namely:

- (1) How is mental health understood and constructed?
- (2) To what extent are children able to participate and have their voices heard within mental health structures?
- (3) How are therapeutic interventions evaluated by children?
- (4) Is there a role for EPs within mental health?

The first three research questions are reflected in the thesis title: 'An Exploration of Mental Health Constructions and Children's Evaluation of a Local Authority's TaMHS Therapeutic Resource'. The fourth question is implied as I argue in the following chapter that EPs are able to perform an essential role within the context of mental health.

Chapter 2

2 The Literature Review

2.1 Introduction

The main aim of the literature review is to address the research questions highlighted in the previous chapter. A further aim of this chapter is to emphasise the centrality and importance of a literature review within the research process. The literature provides an exposition of the research questions which the methodology in turn endeavours to answer. Aveyard (2007), in extolling the values of a good literature review, articulates the fact that such an academic investigation seeks to summarise the body of work available on a particular topic or topics and in doing so, the researcher is able to critically analyse the myriad of information available. This, the author adds, is an invaluable exercise for the researcher because she/he cannot be expected to read and assimilate all the information on any and every given topic.

The first part of this chapter illustrates how the initial review of the literature facilitated and provided the catalyst for a more streamlined review to take place. This review, it could be argued, does not adhere strictly to what researchers may consider to be a pure systematic approach. Here the literature is critiqued at first as a whole body of work from which themes emerge. In other words, this review is a critique of the themes that first of all emerge from the literature rather than an evaluation of the individual articles themselves which comes later. Examining the relevant literature thus is an effective way of relating directly to the methodology which, in the case of this research adopts a wholly thematic approach. Reviewing the literature in this way

also relates appropriately to the specific research questions which themselves are an exploration of pertinent themes examined within this thesis.

The second part of this chapter is a critique of specific articles that emerge from the literature search. It examines the constructions of mental health, the agency of children within mental health structures, therapeutic interventions and the role of the EP within the context of mental health.

Part 1

2.2 Resources and Initial Themes

The literature review undertaken was serendipitous and to a large extent, systematic. I use the term serendipitous not to reflect a chaotic or haphazard/ad hoc investigation into the literature available but to highlight the fact that there are obvious resources to begin one's initial search, even though the exact content at the point of engagement with the literature is not known. The first thing that was done was to familiarise myself with the government publications mentioned at the end of this section. The deductive discursive approach of the relevant literature more common in systematic reviews came later. The review of the literature was therefore at first theme-led and this resulted in mini-literature reviews taking place rather than an all encompassing one covering all the themes and research questions.

The obvious subject matter-related resources that I used were current and back issues of the following journals:

Table 2.1 List of Relevant Journals 1

Journal Name	Period Reviewed
British Journal of Educational Psychology	2009-2011
British Journal of Clinical Psychology	2010-2011
British Journal of Developmental Psychology	2009-2010
British Journal of Social Psychology	2009-2011
Educational Psychology in Practice	2004-2011
Emotional and Behavioural Difficulties	2000-2011

I only reviewed relatively recent journal articles from the first four bibliographic resources listed above because they were never intended to be the main ones used in this particular research. An earlier preview of the aforementioned journals was undertaken in January 2010. The review covered all the four journals from 2005 to 2009. The journal articles that I found bore very little relevance to the issues this thesis intends to address. There were some relevant articles which touched on issues which, in the context of this research could be regarded as peripheral

because they did not form the main focus of the thesis's arguments. A difficulty with phonics, for example, is an issue addressed in a number of journal articles in the *British Journal of Educational Psychology*. Research has shown that difficulty in a child's understanding and application of phonics usually results in delayed development of literacy skills and subsequently to pupil alienation within the classroom (Favart and Passerault, 2009; Alcock et al 2010; Dockrell et al 2010). Although research into this area of difficulty is of measurable value, in my research however, I was more interested in the ecological and environmental factors which directly impinge on pupils emotional and social well-being which then adversely interacts with their access to learning within the classroom.

The final two journals in the table, that is, *Educational Psychology in Practice* and *Emotional and Behavioural Difficulties* appear to be more relevant to the subject matter and research questions being addressed in this thesis. *Educational Psychology in Practice* is more practice-based and therefore addresses the role of the EP working within different educational and organisational structures. This is of utmost relevance because; the role of EPs within mental health paradigms will be shown in subsequent chapters to be of great and immediate importance. *The British Journal of Clinical Psychology* is a relevant resource and as the subject domain within this thesis straddles the divide between the areas of clinical and child/educational psychology. Articles covering specific mental health issues such as anorexia nervosa (Higbed and Fox, 2010) and self harm (Gilbert et al, 2010) added a degree of value to the research and understanding of the various ways in which mental health difficulties are expressed and realised within educational paradigms. This is not to suggest that there was no value in the other journals. In *the British Journal of Developmental Psychology*, for example, the article by Wolke et al (2009)

delves into the issue of bullying in primary schools and Nesdale et al (2009) researches the incidence of peer rejection in schools. The point being raised here is that even though some journal articles were relevant to this research, they were very few and far between.

Before a more systematic review of the relevant literature took place, an attempt was made to search the literature available in relation to TaMHS. Being a relatively new initiative, I could not locate any peer-reviewed literature on the subject. Additional information on children and mental health was therefore found in selected government publications, for example, CAMHS Reviews, (DoH, 2008a, 2008b), SEAL (DfE, 2010) and general mental health initiatives (DfES, 2004, DoH, 2011).

Part 2

2.3 The Systematic Research for Relevant Literature

After the serendipitous search of relevant literature including the aforementioned government publications, it was imperative to undertake a more systematic approach in order to achieve a more streamlined search. Aveyard (2007), in discussing the value of a systematic literature review, asserts that it endeavours to identify and trace all the available literature on the topic and in doing so, describes a clear and comprehensive methodology. The author adds that such reviews are best defined as a succinct précis of the most appropriate and available evidence that addresses sharply defined pertinent questions.

In addition, Aveyard (2007) also states that a feature of systematic reviews is the adherence to a strict protocol that researchers are required to follow; this is in order to ensure that the critical appraisal of the specific literature reviewed relates to

predefined questions. The systematic part of the review was completed in four simple stages:

- The selection of relevant databases from the relevant online catalogues
- The input of specific keywords and terms into the relevant search engines
- Establishing the criteria for the inclusion and exclusions of academic journals
- The creation of themes from the literature available in conjunction with the thesis' research questions.

At first I tried to encompass all the elements of my thesis into one thorough literature search, to do this the Educational Research Information Centre (ERIC), library database was accessed on 13 March 2011. The search showed no entries when the keyword TaMHS was entered, however 26 articles were highlighted when the keyword CAMHS was entered. The 26 journal articles highlighted, although of interest, were discarded because the majority of the papers did not specifically relate to the constructions of mental health, the expression of mental health difficulties within primary schools or any other element highlighted within the thesis title.

Secondly, the information gathered regarding CAMHS did not reveal any other detail not already highlighted in the CAMHS Reviews (DoH, 2007, 2008). Therefore to widen the area of search, the key term 'Mental Health' was entered into ERIC and this produced 109,708 journal articles. It was practically inexpedient to review over 100,000 journal articles and so the original search was discarded and an additional search was undertaken. It was also difficult to encapsulate all the themes of the thesis within one literature search. To ensure that all the elements highlighted in the thesis title were addressed, a more streamlined search was undertaken. The criteria

for including and excluding journal articles depended on whether the articles revealed were relevant to the keywords within my thesis title and research questions.

Aveyard (2007) explains:

Inclusion and exclusion criteria enable the literature reviewer to identify the literature that addresses the research question and that which does not. The criteria you develop will be guided by the wording of your research question and will enable you to articulate the focus of your research

(Aveyard, 2007, p.59)

The journal articles in the table below were the ones eventually chosen. The process in which they were selected is explained afterwards.

Table 2.2 Literature Review Table 2

<u>Author(s) & Year</u>	<u>Journal Title</u>	<u>Method</u>	<u>Participants</u>
Theme: <u>The Construction of Mental Health</u>			
Wright et al (2011)	Labels used by young people to describe mental disorders: which ones predict help-seeking choices	Quantitative: Computer assisted telephone survey	3,746 children/young people aged between 12 and 25
Jones (2003)	The Construction of Emotional and Behavioural	Qualitative: A critique and review of existing literature	Not applicable
Taylor et al (2010)	Labelling and Self-esteem: the impact of using specific vs. generic labelling	Quantitative: completion of Culture-Free Self-Esteem Inventory and a standard test of reading ability	75 children between the ages of 8 and 15
Theme: <u>The Participation of Children within Mental Health</u>			

Mizrahi et al (2009)	The Social Construction of Client Participation: the evolution and transformation of the role of service users in child welfare and mental disabilities	Qualitative: A comparative analysis of client participation in child welfare programmes	Not applicable
Day (2008)	Children' and Young People's Involvement and Participation in Mental Health	A review of existing literature	Not applicable
Hall (2010)	Supporting Mental Health and Wellbeing at a Whole- School Level: Listening to and Acting upon Children's Views	A single school case study design using focus groups and semi-structured interviews	18 children from Reception class to Year 6
Sellman (2009)	Lessons learned: student voice at a school for children experiencing social, emotional and behavioural difficulties	Qualitative: Focus groups	6 boys between the ages of 13 and 16
Theme: <u>Therapeutic Interventions in Schools</u>			
Atkinson et al (2011)	Educational Psychologists' use of Therapeutic Interventions: issues arising from two exploratory case studies	Qualitative: Two small-scale research studies using focus groups, semi-structured interviews and thematic analysis	17 Trainee EPs
Theme: <u>The role of the EP within Mental Health</u>			
Rothi et al (2008)	Recognising and Managing Pupils with Mental Health Difficulties: teachers'	Qualitative: Semi-structured interviews and interpretative phenomenological	30 teaching staff between the ages of 25 and 65

	views and experiences on working with educational psychologists in schools	analysis	
Dawson and Singh- Dhesi (2010)	Educational Psychology Working to Improve Psychological Well-being: an example	Quantitative: A statistical review of an intervention using SDQs and focus groups	45 Year 5 children, 71 Year 6 children and 85 parents

2.3.1 The Construction of Mental Health

It has been said throughout this thesis so far that TaMHS is a resource that can be accessed by pupils in their various schools. Unlike adults within the NHS who can refer themselves to their GPs at any time, children are unable to access TaMHS therapeutic interventions without being referred by their teachers or other relevant members of the school staff. All the referrals for TaMHS in my local authority were made by teachers and other relevant members of staff. Having to 'diagnose' or label children as having significant emotional difficulties in order for them to access TaMHS therapeutic interventions is a role in which a number of teachers have said they lack the necessary expertise in. According to the research report for NASUWT (2005) teachers find this additional role imposed on them difficult to perform. The report states that teachers' areas of expertise does not include the identification and diagnosis of mental health disorders within the classroom as this has never formed part of their initial teacher training. The report adds that, due to this fact, there is reluctance on their part to fulfil this additional role.

Regardless of whether schools and teachers feel competent enough in constructing and identifying incidences of mental and emotional ill health within the classroom,

within the wider scheme of Special Educational Needs, parents have actively sought their constructions and indeed labels, especially if the resultant effect leads to more resources and support for their children within the classroom. Goldstein et al (1975), for example, suggest that certain labels serve as a passport to accessing special education and the resources associated with it. This view is supported by Archer and Green (1996) who state that the acquisition of a label or a construct by a teacher alleviates the strain, stress and anxiety for parents. In such situations parents no longer see the problems experienced by their children as their fault but due to the label their children have acquired, be it Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) or a mental health problem requiring medical and/or therapeutic interventions. This was the background on which the literature review regarding the constructions of mental health was based on.

The literature search into the constructions of mental health proved to be problematic because the search conducted via ERIC at first did not produce any material that met the inclusion criteria. The inclusion/exclusion criteria was four-fold: (1) the constructions had to relate to children and young people alone; (2) the constructions had to relate to mental health in general and not specific mental health disorders; (3) the constructions of mental health patients in mental health institutions were not to be included; (4) only academic journals were to be considered in the search.

ERIC was accessed on 26 July 2012 in which the words 'Constructions of Mental Health' were entered into the search engine. The search highlighted 223 articles but none of them related to the inclusion/exclusion criteria. The keywords: 'Definitions of Mental Health' were then put into the search engine which resulted in five articles being highlighted, none of them matching the inclusion/exclusion criteria though. Other combination of words were tried such as 'Mental Health Constructs' (359

articles), 'Mental Health Constructs, UK' (25 articles), 'Constructs of Children's Mental Health' (26 articles), 'Social Constructions of Mental Health' (88 articles) and 'Social Constructions of Mental Health in Children' (41 articles). None of these combinations of keywords resulted in articles matching the inclusion/exclusion criteria.

A decision was made to change the keywords because ERIC had not come up with journal articles suitable for this thesis. ERIC was therefore accessed again on 26 July 2012. I then substituted the word 'Construction' for 'Labels/Labelling'. When the keywords 'Labels of Mental Health' were entered into the search engine, 102 articles were highlighted of which only one partially matched the inclusion/exclusion criteria which was Wright et al (2011).

To complement this article I specifically undertook a manual search in the Open University library and located two relevant journals, namely: *Educational Psychology in Practice* and *Educational Psychology: An international journal of experimental educational psychology*. Two relevant journal articles were located respectively, namely: Jones (2003) and Taylor et al (2010).

Wright et al (2011) look at the positive aspect of labelling and constructions of mental health because according to them, accurate labels enable young people to access mental health services relevant to their needs. They first of all differentiate between labels and actual diagnoses. Labels they stress refer to the lay descriptors used to illustrate the mental health difficulties being experienced. In doing so, the authors explain that professionals are able to meet such young people at their point of need. In their research they add that young people who identified their difficulty as a mental health problem were six times more likely to have it correctly identified by the

General Practitioner (GP) than those who were unable to attach a label or description regarding how they were feeling. The research undertaken by Wright et al (2011) was based in Australia and was a computer assisted telephone survey of 3,746 people aged 12-25. Each person was given a vignette of a mental health case study and they were asked what they felt was wrong with the principal character in the vignette. What the study does not account for is the level of English comprehension and verbal expression each person had. In their sample 16.6% of the respondents spoke a language other than English at home and 3.3% of them were of Aboriginal origin but there was no way of knowing how competent each respondent was in English. I raise this point because being able to describe how one feels depends a lot on a person's competence and confidence in language communication, this becomes a more pertinent issue with younger children who may not have the repertoire of words when asked to explain the way they are feeling. This highlights the symbolic interactional aspect of language. Symbolic Interaction (SI) as espoused by Goffman (1974) highlights the importance of communication and language within socio-cultural contexts. People interact and find meaning through communication and so it is language that we must use as a cultural tool and artefact in understanding various cultural views and perspectives (Miell et al 2002). SI postulates that meaning is deduced within the culture it operates and influences the way the speakers of the language see and understand the world around them (Reynolds and Herman-Kinney, 2003). Apart from being the social artefact in which meaning is derived, it is also structured in ways that underlines power and authority. According to Burr (2008), central to social constructionism is social interaction and the way in which language is used as a medium from which deconstructions are derived:

Deconstructionism emphasises the constructive power of language as a system of signs rather than the constructive of the individual person. It is concerned with how the human subject becomes constructed through the structure of language and through ideology

(Burr, 2008, p. 17)

Therefore deconstructions and co-constructions are integral to social constructionism as these are tools in which dominant discourses and knowledge bases may be challenged. Rixon (2011), in explaining this point further adds that the emphasis on power in practice relationships is open to scrutiny, as well as how practice can be co-constructed between practitioners, children and young people. The importance of language competence therefore cannot be over-emphasised because apart from the respondents' competence in language a power dynamic is revealed. Wright et al (2011) stress that the power differential within researcher/respondent relationships is such that the former assumes and appropriates meaning based on the information revealed during the telephone survey. Being able to appropriate meaning to the information gathered during the research process is an indication of the power the researchers have over the respondents. Notwithstanding, even though the authors do not highlight the significance of language expression and comprehension among the younger children in their sample, their research was still able to highlight the importance of being able to describe and label their difficulties in order to access the most relevant resources.

Jones (2003) unlike Wright (et al, 2011) focuses on structural constructions of emotional and behavioural difficulties. In this paper a link is made between EBD and learning difficulties as highlighted within the SEN Code of Practice (DfES, 2001).

Within this paper it is argued that education specific legislation, such as the

Education Act 1981, has within it the power to construct and define children's difficulties within schools and suggest ways in which these difficulties may be alleviated. The author asserts, has allowed policy makers to sign-post children with EBD (but with no other cognitive disorders) to resources more commonly accessed within health, for example, CAMHS. The author's argument here is that prior to the aforementioned Education Act children with EBD were constructed as being maladjusted, which in turn is a function of psychopathology. In other words, policy makers were able to make cogent links between children with EBD and psychopathology. Psychopathology incidentally locates such children within the medical model of health and disability. Jones (2003), however; takes the view that children with EBD should be viewed and understood within the social ecological perspective as espoused by Brofenbrenner (1979) and not the medical model. A counter argument that could be put forward though is that whether one is allied more to the medical model or the social ecological model is of no real significance because both perspectives incorporate labels and constructs into their exploration and understanding of particular aspects of children's health. This is not to say that the two competing models are not relevant within this context. A more current debate within the mental health paradigm can be seen within multi-agency partnerships where the medical model and the social ecological model struggle for supremacy. Jones (2003) sums up the debate by saying that the medical model was incorporated into education by equating 'maladjusted pupils' with disabled pupils and then referring such pupils to child guidance clinics, which in effect prioritised therapy over educational goals. An issue that the author does not cover is the transition from EBD to psychopathology. The question therefore is: when does EBD become psychopathology? The transition from mental health to psychopathology cannot be

accurately defined or plotted as such a transition is not necessarily linear because behaviours that are considered normal and healthy in one context and culture might be considered abnormal in another. This highlights the significance of terminology in determining behaviour. Nylund (2000) believes terminology is very important because it sets concepts and phenomena within contexts and parameters although it can still leave room for ambiguity. Due to our subjectivity, the author adds that two people could observe exactly the same behaviour but arrive at totally different outcomes. In other words, two teachers may observe the same behaviour in a child with one teacher perceiving the behaviour as a problem and the other accepting it as normal.

Taylor et al (2010) adopts a slightly different perspective from the other two papers hitherto discussed. Here the authors are more concerned about the cogent links between labels and the self esteem of children. They put forward the view that labelling can have both a positive and a negative effect on children. The authors add that labelling can reveal the dynamics of power that operate within various groups. Schools, they stress are examples where such power dynamics operate. Children who are members of dominant 'in groups' may choose to appropriate negative labels to those who are outside of such groups. Such negative labels and the continual use of them is tantamount to bullying which in turn has the potential to adversely affect the victims' self esteem. Taylor et al (2010) are quick to emphasise that labels are not always negative as children may choose to use benign labels to differentiate different groups of children within school such as 'goth' and 'emo' or assign positive labels to highlight certain abilities in others such as 'sporty' and 'brainy'.

The viewpoints of Taylor et al (2010) have some congruency with the Wright et al (2011). As with the perspective adopted by the latter, Taylor et al (2010) too are of the opinion that within SEN paradigms labels appropriated by educational professionals may lead to children being able to access the necessary support and resources. They, like Jones (2003) also highlight the influence of the medical model on mental health which they say is clearly present in the SEN Code of Practice (DfES, 2001) which locates problems displayed by the child, within the child, and not the environment. In addition the authors claim that the labels children are given in order to access the much needed support and resources confirms the prevalence of the deficit model. Children, they add, have to display apparent behaviours that affect their access to the school curriculum before an appropriate resource is offered. To counter this issue Taylor et al (2010) put forward a stance adopted by Lauchlan and Boyle (2007) who call for the adoption of a social ecological understanding of mental health rather than the reliance on labels. Lauchlan and Boyle (2007) also assert that labels promote a within-child deficit model and create situations whereby environmental factors and how they impinge on a child's well-being are not taken into consideration. This once again brings into the fore issues relating to the medical and social models of disability. The former relates more to within-child model while the latter clearly focuses more on the environmental perspective.

Taylor et al (2010) in explaining the influence of the medical model in labelling and the provision of resources are also quick to highlight the importance of a child's emotional/mental health and its relevance to their general welfare at home and in school. In their view there has been a lot of deliberation over the terms used to describe a particular aspect of a child's well-being but what needs to be explored further is why constructs and labels are of significance within the health and social

care systems. In doing so, the spectre of power in both the medical and social structures pertaining to mental health needs to be explored. For mental or emotional ill health to exist there has to be an opposite and equal counter-balance - good mental and emotional health. This raises the issue regarding who decides what norm is in relation to mental health. Although Taylor et al (2010) do not directly address this question, it would be apt at this point to refer to other authors who do because within this question is the issue of power and in turn the authority to appropriate labels within SEN paradigms.

The issue regarding which model is favoured over the other relates more to discourses which have within them, specific ideological constructions. Within the paradigm of mental health, the issue and the realisation of the power of the professional over the client/service user is always of immediate concern. Foucault (2006) plots the history of mental health and the dilemma professionals face regarding whether treatment or control is the most suitable form of intervention. Layder (1994) in explaining Foucault's view says that the true value of meaning is a product of the internal relations and interactions between elements of the discourse which define and facilitate the social practices of individuals. Layder (1994) adds that people therefore live their lives through the constructed meanings available to them. Taylor et al (2010) appropriate this to labels that have the power to define and affect the lives of children within school.

A professional's understanding of mental health therefore will be based on the social discourses which position subjects in a field of power relations and within particular sets of practice. Britzman (2000) explores the idea that discourses have the power to include and exclude groups of people cognisant on what is considered normal and abnormal behaviour respectively. The author adds that discourses authorise what

can and cannot be said and in doing so they control the power dynamics within structures.

2.3.2 The Participation of Children within Mental Health

According to the Elton Report (DoES, 1989), pupils are not passive recipients of education but active agents in their own learning and perception of needs. The report further claims active agency or social pedagogy can only be realised and maintained when structures within schools encourage participation and communication between pupils and their teachers. There is an argument to be put forward suggesting that the ideal of children as active agents within the structures of education, and to some extent health, is a goal in which children should aspire to but will not necessarily attain due to their relative powerlessness in society which constructs children as being incapable of independent agency (Lansdown, 2011).

The claim that children in general are relatively powerless is arguably a fact of modern society and societies before them. This position of powerlessness, it could be argued, can be addressed by giving children the right to participate in situations that directly affect them. Article 12 of the UNCRC 1989 supports this notion as does relevant child related legislation in the UK. The Children Act 1989 (Bridge et al, 1990), for example, stipulates that in all issues that affect the child, their wishes and feelings should be ascertained. Children's participation therefore forms a significant element within the literature review.

On 5 June 2012 as a result of the chapter being reviewed further, ERIC was accessed again. The keywords: 'Children's participation' were entered into the search engine. This search produced 2860 relevant articles. As the volume of articles highlighted within the search engine was quite large, a more concerted

approach was taken and so the words: 'Children's participation in mental health' were entered into the database's search engine. This produced only 15 articles in which only two were chosen.

The list below highlights the inclusion/exclusion criteria used:

- Number of journal articles produced by ERIC = 15
- Number of journal articles dealing with adolescent participation alone (and not children) and therefore excluded = 5; remaining articles = 10
- Number of journal articles dealing with severe mental health issues within medical institutions and therefore excluded = 2; remaining journal articles = 8
- Number of journals articles in which children's participation was not the main or central focus = 6; remaining journal articles = 2
- Number of journal articles in which children's participation in mental health formed the main focus = 2; 2 journal articles were therefore included.

The search resulted in two journal articles being chosen, Mizrahi et al (2009) and Day (2008). Two other journals that were not highlighted in the online database search were also included because of their relevance to this particular theme. These two articles were taken from the *Journal of Emotional and Behavioural Difficulties* following a manual search. The two relevant journal articles chosen were Hall (2010) and Sellman (2009).

Mizrahi et al (2009) take on a sociological perspective regarding the role and voice of children within mental health structures. Their journal article presents a comparative analysis of children's participation and in doing so identify three rationales in which their participation is based, namely: Philosophical, Pragmatic and Political. More

importantly the authors view the participation of children within mental health structures as a social construction in its own right:

The 'power over' paradigm with respect to the social construction of the persons with mental health disabilities also has been shaped by medical and psychiatric authorities with the sanction of government to involuntary institutionalised and even incarcerate clients

(Mizrahi et al 2009, p.38)

Mizrahi et al (2009) add that the response to the child's voice is usually subjected to a process of invasive and intrusive labelling and hierarchical valuation derived from powerful social and health structures who assign appropriations of mental health illness to such recipients of mental health care.

The general participation of people within mental health structures is constructed by the professionals involved. What Mizrahi et al (2009) point out is that patients are constructed as having very little medical understanding of their illnesses/difficulties and so the extent to which they are allowed to participate in their own care is significantly limited. These patients are then constructed as passive recipients of medical care. They explain further that within mental health structures, children in relation to adults have even less power because they are constructed within the paradigm of helplessness as having no insight into their medical difficulties.

Foucault (1980) agrees with the premise mentioned above and postulates that the powers to decide what the norms are within the structures of mental health are the agents and recipients of power themselves. Within the structures of health, the agents and recipients of such power are the doctors and specifically in relation to mental health, psychiatrists. Thus Mareck and Hare-Mustine (2009) suggest that

definitions and constructs of normative values and situations in relation to mental health only serve those who have the power to diagnose and decide. The power to define and label a group of people, they claim, is evidence of control over that particular group of people. Within social constructionism is the understanding that certain people have the power to define and exclude. It is a person's degree of emotional well-being as defined by a professional or professionals that will decide what kind of educational, therapeutic or medical interventions are provided. In order to advance our understanding of children's participation further Mizrahi et al (2009) discuss this concept under three paradigms first mentioned at the start of this section:

Philosophical: Here children's participation is seen as essential if any practice is to be deemed democratic or service user led. The more children are involved, the greater their self esteem and self-efficacy will be. Essentially, the philosophical perspective focuses on service user participation as a means of empowerment but what is not made clear is the specific legislation that empowers such participants. In the UK, legislation such as the Children Act 1989 which draws heavily on the UNCRC 1989 empowers children to become involved in the matters that affect them by establishing parameters in which professionals have to include them. The authors; however, do not highlight any aspect of these legislative rights children may have, which in my opinion is a weakness of the paper.

Pragmatic: According to this perspective, the true way in which children will be able to be part of the service delivery aimed at them is to gather their views in the form of feedback related to the care they have received. This view highlights a limitation of this paper. Here children are constituted as a homogenous group rather than a diverse one with different abilities in terms of social and cultural. The extent to which

children are given a voice within such structures is not only dependent on the professionals ceding some of their power in order to accommodate the views of children; it is also dependent on the children themselves. Some children may be unable and/or unwilling to be part of the feedback process.

Political: This perspective aggregates the power of a group of children as being able to speak with one voice. The authors are of the opinion that an organised stakeholder base can develop a collective voice by developing an invested, articulated and unified approach. The authors stress that such an approach fosters a sense of social consciousness and a collective identity. It should be emphasised here that the paper is for a North American audience where mental health service provision is different from that undertaken in the UK. The issue of having a collective voice at this present point in time is not something that is factored into TaMHS, hence the need for this thesis to collate the views of children regarding their evaluation of this therapeutic resource. The delivery of TaMHS in my local authority was done on a one-to-one basis between the therapist and the child; group sessions with other children did not arise. The authors, however, acknowledge the limitations of their paper, for example, they admit that no original qualitative or quantitative research was carried out and so invariably the opinions of children were not independently sought. The authors also acknowledge that only a very general view of service user participation was taken and so their responses have to be taken as such.

The perspective adopted by Day (2008) is different from that of Mizrahi et al (2009). First, this paper focuses on mental health service delivery within the UK and is therefore linked to UK healthcare policy. Rather than focus on the social construction of participation, it looks at more practical means of getting children involved in their

own service delivery regardless of their age and ability. Within this paper it is argued that the views of very young children should be sought and taken into account when planning, improving and evaluating services. The author further argues that the diverse needs of children have to be taken into account in order to include those from excluded groups such as children from Black and Minority Ethnic (BME) groups. Popular constructions of children and childhood lends itself to the creation of children and young people as immature and incapable of making informed decisions when it comes to matters that affect them. Amato and Tree (1987) studied a group of primary school children and concluded that children, through the ages have at times been considered too immature, inarticulate or shy to serve as useful sources of data within qualitative approaches to research. A congruent view is adopted in the SEN Code of Practice:

Children have important and relevant information. Their support is crucial to the effective implementation of any individual programme... Schools should therefore make every effort to identify the ascertainable views and wishes of the child or young person about their current and future education

(DfES, 2001, section 2.4)

Day (2008) asserts that the issue of children's participation is a pertinent one considering their paucity of representation within formal societal structures. Despite better representation in schools via school councils and the advent of Children's Commissioners (in England and Wales) which in turn epitomises greater participation of children within democratic processes, children, it could be stated, are still required to operate within adult defined spheres (Foley and Leverett, 2008).

Unlike Mizrahi et al (2009), Day (2008) juxtaposes children's participation against models that highlight degrees of participation. Day (2008) is aware that participation

is a relative term and so can range from tokenism to full participation. The first model the author critiques is by Hart (1997) who proposed an eight step/rung 'Ladder of Participation'. The first three levels, manipulation, decoration and tokenism are to all intent and purpose, examples of children's non-involvement. The next five steps, however; depict varying levels of active participation leading up to 'child initiated shared decisions'. Although this model helps us to understand varying forms of non-participation, Day (2008) argues that a hierarchical form of participation/non-participation is not all that helpful and so offers Treseder's (1997) model of participation as a critique of Hart's Ladder. Treseder's model offers a non-hierarchical construct of children's participation highlighting that in certain social contexts like schools children may not have the required level of power/control in order to reach Hart's highest level. Foley and Leverett (2008) add that Treseder's model acknowledges that although some children may wish to participate, they may do so at a level that best reflects their abilities, resources and ambitions. Another positive aspect of Treseder's model is that it does not assume that children constitute a homogenous group; the level of participation is based on children's innate ability and choice to take part in matters that affect them.

Day (2008) also differs from Mizrahi et al (2009) on account that the former's paper relates to the UK and therefore understands the structures that are in place to facilitate children's participation, for example the Children Act 1989. It also relates to mental health resources such as CAMHS, although not TaMHS because it was not in existence at the time the paper was written. Day (2008) gives the impression that children's participation is a work in progress and equates power and having a voice, not only in relation to children but also in relation to the barriers in the form of structures and professionals they potentially have to face:

Potential barriers include feeling intimidated by professionals, lacking confidence to voice opinions, and a lack of faith in their own views will be influential...Whether this is an issue of distraction depends on the purpose of involvement

(Day, 2008, p.5)

As with Mizrahi et al (2009), Day (2008) too has its limitations. Like the former, it is an opinions/discussion paper rather than a research paper. Original research highlighting the extent to which children feel confident and competent in participating with professionals and structures would have given this particular paper more depth and robustness.

The third paper in this section is Hall (2010) where the author stresses the importance of listening to children within school settings. This is a departure from the first two papers reviewed because it takes account of what happens in schools and makes particular reference to TaMHS and SEAL. Unlike the previous two papers Hall (2010) focuses on research which was undertaken in a particular school by two EPs and a TEP (Trainee Educational Psychologist). The main focus of the research was on listening to children's views within mental health paradigms.

As with Day (2008), Hall (2010) approaches the idea of children's participation by first of all highlighting Hart's (1997) ladder of participation and comes up with the same criticism of it. The author argues that because participation is such a stringent task within Hart's construct, it would be difficult for children to get past the first two rungs which ostensibly equates to tokenistic participation. What Hall (2010) does advocate however; is a three tier participatory model comprising of the following:

- **Consultation-focused organisations:** Within this tier children are consulted and their views are fed back in order to inform services directed at them
- **Participation-focused organisations:** Here children and young people are seen as part of the decision making process thereby signifying full involvement
- **Child/youth-focused organisations:** Within this tier children and young people's views are central to decision making. Here children and young people's views are not distinctively targeted but because their views are central to the culture of such an organisation their wishes and perspectives are at all times made known.

Hall (2010) does not highlight the method for collecting children's views within these participatory tiers. As no more detail is given and not referred to again, the model appears to be isolated from the rest of the paper. Hall (2010) does however, stress the importance of school based initiatives such as SEAL and TaMHS and the legislative imperative laid down by the Children Act 1989 regarding participation. The author also locates these initiatives within social ecological discourses which at their helm is the belief that the identification of emotional/mental ill health in schools and the provision of appropriate therapeutic interventions would reduce the need for children to seek medical/pharmacological interventions in the future. The author adds that traditionally, EPs have tended to work within a medical model by highlighting emotional and academic problems in children by way of administering standardised assessments. Through TaMHS and SEAL, however; EPs are able to use approaches such as collaborative solution-focused work to elicit information from children and in turn improve their emotional outlook. Hall (2010) puts forward the idea that children's agency within predominantly adult structures serves as building

blocks for their identities because through participation choices are made and in turn these choices reflect their preference for one thing over the other. This is in line with Christensen (2004) who in advocating that the views of children be considered, argues that by doing so, adults can begin to understand the over-arching rubric of children's thinking and how it relates to our understanding of the social and cultural world in which they inhabit. When children have the opportunity to make preferred choices it acts as an insight into their own difficulties and particular identities.

Hall (2010) adds that emotional and behavioural problems in school and in later life are well documented. The author asserts further that such difficulties will be alleviated if children are afforded free and active participation within mental health resources. This view runs contrary to the perspective postulated by Marecek and Hare-Mustin (2009) who introduce an interesting concept in relation to children's active participation within the context of mental health. By adopting a more Foucauldian stance, the authors suggest that adults experiencing mental ill health are never really regarded as credible adjudicators of their experiences or of the treatments receive. If adults within mental health paradigms are disempowered by discrediting or ignoring their experiences, it can be surmised that children are even more disempowered.

Hall's (2010) paper sets out the methodology used in the research. The views of the children were elicited and collated through age specific focus groups. The participants within the focus groups in turn were asked semi-structured questions which revolved around a particular framework. The framework in question consisted of five main themes: (1) environmental quality (2) self-esteem (3) emotional processing (4) self-management (5) social participation.

The outcome of the research was considered to be positive because each focus group was able to present important ideas regarding the ways in which mental health needed to be addressed in schools.

Hall (2010) admits to the inherent limitations of focus groups, for example, the fact that it was not possible to involve all the school children in the research. The paper is also scant on the process of data collection. Apart from the school sending out letters of consent to parents, the author does not highlight the procedure for selecting children in the first instance. What is stressed however, is the importance of EPs in enhancing children's participation within schools. The author emphasises the point that EPs are well placed and competent in encouraging children's participation through the ways in which they work.

The final journal article reviewed in this section regarding children's participation is Sellman's (2009) paper which looked at Social Emotional and Behavioural Difficulties (SEBD) and children's participation. The research was undertaken in a SEBD school for boys.

As with Hall's (2010) research, Sellman (2009) too elicited and collated the views of pupils from a focus group. The focus group in question comprised of six male pupils. At the beginning of the paper, reference is made to the UNCRC 1989 which advocates for children's full and open participation. The author however juxtaposes the principle of participation as enshrined within the UNCRC 1989 with the principle of participation as stated in the SEN Code of Practice (DfES, 2001) which does not oblige schools to involve children who are deemed as having special educational needs, in decision making. On the basis of this premise the author argues that pupils with SEBD fall into the latter category and are ostensibly more likely to face school

exclusions, which in turn diminishes their voice and right to participation even further. The issue of inclusion and exclusion is raised further by the author and in doing so explains what the difference between empowerment and genuine involvement is:

It is important at the outset to differentiate between pupil empowerment initiatives that simply seek to give students opportunities to be heard and genuine involvement in truly democratic schools

(Sellman 2009, 34)

Sellman (2009) explains that the latter, that is, genuine involvement, is much harder to achieve than the former. As with Hart's (1992) ladder of participation Sellman (2009) believes that pupil empowerment initiatives are tantamount to tokenism as their inclusion within the structures of the school are limited to litter picking rotas and attendance at periodic school councils. The author argues further that the pupils involved in such so called democratic processes usually conform to adults' version of a good pupil and are therefore included within structures devised by them. The crux of the author's argument is that if mainstream pupils are afforded no genuine participation in school, then those who are in specialist provisions due to their emotional and behavioural difficulties will find it harder to make their own voices heard.

Although it is clear that the UNCRC 1989 and the Children Act 1989 empower children to express their views and in doing so, participate within the structures that impinge upon their well-being, there is a danger if care is not taken, to assume that all children and young people have the same capacity to express their views as effectively as each other (O'Dell and Leverette (2011).

A way in which to ensure that we do not have unrealistic expectations regarding children's participation and therefore agency is not to construct children as if they constitute a homogenous group. Woodhead (2006) encapsulates this viewpoint effectively and succinctly when he points out that adults should not construct childhood as a general, homogenous and decontextualised progression of development towards a taken for granted state of maturity. The author, in addition, suggests that such a view potentially pressurises children to engage in processes that they may not want to or feel competent enough in, without suitable guidance and assistance.

Sellman's (2009) rationale for undertaking this research was based on the fact that very little research had been undertaken which encapsulated the voices and views of SEBD pupils excluded from mainstream schools and more specifically their perspectives regarding physical restraint as an effective or outdated mode of behaviour management. All six participants gave their consent and this was sanctioned by their parents who signed the appropriate consent forms.

Sellman (2009) describes the dynamics of the focus group as being very macho and to some extent homophobic in nature; for instance, when collegiately agreeing appropriate behaviour, one of the students wanted 'no gay touching' as a ground rule. Through negotiation it was termed differently as respecting each other's personal space. The author mentions that the group met on six occasions but two of the sessions did not have the full complement of participants due to some behavioural issues that had occurred in the main school. This resulted in the pupils concerned opting not to attend the focus group. Overall, the author reports that each pupil was given time and space to air his views regarding physical restraint in school

and how behavioural management could be made more acceptable to them. The report findings highlight an important issue that the students at the provision found acceptable. They were accepting of the fact that on occasions, physical restraint may be needed but according to them, it had to be carried out safely by trained, competent and confident adults.

It could be argued that Sellman (2009) achieved the main aim of his research in that he was able to collate the perspectives of pupils whose views (historically) are rarely sought due to the SEBD label that is ascribed to them. Sellman (2009) explained his role within the focus group meetings as that of a facilitator who guided the discussions rather than imposed his own views on the participants. The research, although credible, is not without its limitations. As with Hall (2010), the author focused his research on a single school thereby highlighting the potential of interviewing the same type of student repeatedly. SEBD schools have in common the fact that the students who attend them have been excluded from mainstream schools. Excluded students may, due to their own experiences of mainstream schools, potentially inculcate a negative notion of education in general. Although the students in this study highlighted some salient points about the use of physical restraint, there was the potential for the students to feel negative about everything related to their education to date.

As previously mentioned, the school in question was a boys' only setting and so gender diversity and balance was not possible. Juxtaposing Sellman's (2009) research with an SEBD school for girls, for example, or a co-educational one would have given the study more depth and breadth.

2.3.3 Therapeutic Interventions in School

The main aim of TaMHS was for children within schools to access a myriad of therapeutic interventions as a way of alleviating their emotional/psychological difficulties. Each of the participating local authorities had set up and delivered TaMHS in the best way they felt met the needs of the children, and utilised effectively the services they had on offer.

The review undertaken of the current literature on therapeutic interventions in schools revealed that there are a number of points of intersection or similarities with the final theme (The Role of the EP within Mental Health) and so a strict division between the two themes was difficult to accomplish.

ERIC was accessed on 29 July 2012 and the keywords: 'TaMHS Therapeutic Interventions' was entered; this produced no results. The keywords 'Therapeutic Interventions in Schools, UK' was then entered into the search engine and this produced 19 journal articles. The inclusion/exclusion criteria is highlighted below

The number of journal articles that focused on TaMHS interventions = 2.

The two relevant articles chosen were Atkinson (2011) and Dawson and Singh-Dhesi (2010)

The second journal article was however excluded because it also appears in the literature search for the final theme, that is, 'the role of the EP within mental health'. I felt that the journal article by Dawson and Singh-Dhesi (2010) had more relevance to the last theme reviewed in this section.

Atkinson et al (2011) in making the case for therapeutic interventions in schools highlight the fact that according to the Office of National Statistics (2004) 10% of

children and young people aged five to sixteen have a clinical diagnosis of a mental disorder. The authors add that initiatives such as ECM, SEAL and TaMHS are a reaction to the incidence and prevalence of mental health within UK schools. They argue further that because of such prevalence, the delivery of therapeutic interventions should no longer be seen as the sole responsibility of CAMHS. There is an acknowledgement in their paper that even though CAMHS is an invaluable resource, the referral process is often long and cumbersome meaning that children and young people are at times unable to access the resource. With nothing else to effectively replace CAMHS or fill in the apparent gap, the continual reliance on this resource can only be considered as being counter-productive. In their paper the authors draw heavily upon Farrell et al (2006) MacKay (2007) and Squires (2010) and inevitably put forward the case for EPs to be involved in mental health through the delivery of therapeutic interventions in schools. All these papers assert that due to the training EPs receive and the fact that more than any other outside agency, EPs spend a considerably amount of time working with children and young people in schools, they are the best placed professionals to deliver therapeutic interventions within these settings.

Atkinson et al (2011) are of the opinion that the reason why EPs do not readily get involved in the delivery of therapeutic interventions is because they are often tied down with their statutory responsibilities meaning that it is not uncommon for them to spend most of their time assessing children for Statements of Special Educational Needs.

Regarding the effective delivery of therapeutic intervention in schools and the significant role EPs perform, the authors state:

EPs have been at the forefront of practice concerning specific therapies such as SFBT, EMDR and CBT. He (MacKay, 2007) further postulates that as the evidence base for specific interventions such as EMDR for post-traumatic stress disorder and CBT for mood disorders increases, EPs may appropriately embrace therapeutic interventions and apply them where there are known effectiveness

(Atkinson et al, 2011, p.161)

What Atkinson et al (2011) do not do is delve deeper into the evidence base in relation to a number of therapeutic interventions currently used within schools. Therapeutic interventions, it could be (Pattison and Harris, 2006) it could be argued, are not put through the same laboratory based experimental rigour as pharmacological interventions and so the evidence base regarding their effectiveness compares unfavourably in the light of 'gold standard' research, that is, randomised controlled trials. Current scientific evidence in relation to therapeutic interventions supports Cognitive Behavioural Therapy (CBT) as an effective therapeutic intervention, it also figures prominently in National Institute for Clinical Excellence (NICE, 2008)) guidelines which suggests that CBT is favoured above all psychological interventions. Jones (2008) says that within psychotherapy there is a growing evidence base for the success of CBT in terms of clinical efficacy in the treatment of anxiety, depression and Post Traumatic Stress Disorder (PTSD). The author also states that CBT is a cost effective way in the treatment of the aforementioned mental illnesses. Although Atkinson et al (2011) argue for a greater and more varied use of therapeutic interventions with children, the evidence base for other therapeutic interventions is scant. Pattison and Harris (2006) critically examined four 'talking therapies' (counselling, psychoanalysis, humanistic, and creative therapies) in relation to their effectiveness in the treatment of mental and

emotional conditions as they concern children. Their study revealed no conclusive evidence as to their effectiveness apart from CBT:

The results of the review show counselling to be a positive, useful and effective intervention across a full range of issues presented by children and young people. There is a greater body of evidence for CBT, indicating that this form of counselling may be more effective for older children and adolescents. However, this finding needs to be interpreted with some caution due to the lack of high quality research evidence published in support of other counselling approaches

(Pattison and Harris, 2006, p.235)

Dryden (2007) examines the popularity and accessibility of counselling. Although a very popular therapeutic intervention, he questions its standing when its claims are juxtaposed against its academic rigour or lack of it. The author argues that within psychodynamic contexts, it is not unusual for therapists to concentrate on their clients' inner and subjective thoughts. He adds that the exploration of subjective feelings, coupled with the fact that client/therapist deliberations are confidential, makes it difficult for a more robust intellectual tradition to grow around this form of therapy.

Fox (2009) adopts a different approach from (Atkinson et al, 2011) regarding the evidence base for a number of psychological interventions/therapies. The author accepts that there has to be a clear link between professional practice and research but urges caution in becoming too fixated on positivist paradigms within psychological constructs. He argues that 'gold standard' research within positivist paradigms is the systematic review of randomised controlled trials, and conversely qualitative studies are the least reckoned with within scientific research. Within education, however, there is less clarity about what constitutes good research. The

author acknowledges that positivism in the form of scientific knowledge helps us to understand phenomenon that is real and objective but argues that it is ineffective in the subjective world and the multiple realities people may have within the confines of social constructionism. Fox (2009) adds that the various constructions people have of mental health may be based more on their subjectivity rather than on objective reality. Congruently, psychological interventions other than CBT regardless of whether they meet the 'gold standard' of evidence based research or not appear to be valued within scientific research (Dyrden, 2007). The implication of this however, is that although Atkinson et al (2011) do make particular reference to EPs using therapies including CBT in schools, there is some debate going on that questions whether EPs are suitably trained in order to deliver therapies in schools. The authors do not present a strong case showing how EP training actually enables them to deliver therapies in schools effectively. The paper would have benefitted from a more critical review of EP training in general, highlighting the areas within it that imbue EP with the therapeutic skills and expertise needed to work with children within the context of mental health.

2.3.4 The Role of the EP within Mental Health

Although not explicitly mentioned in the thesis title, the role of the EP within schools and more importantly within mental health structures is a theme that needs to be explored. Furthermore, my research engendered a lot of interest from a number of professionals involved in the delivery of TaMHS therapeutic interventions, namely play therapists, and this in turn highlighted even more that the role of the EP within mental health is an issue that needs to be explored.

ERIC was accessed on 21 June 2012 and the keywords 'Educational Psychology' were initially entered into the search engine of the database, this yielded 24,495 articles. To streamline the search further keywords 'Educational Psychology, Mental Health' were put into the search engine and this highlighted 643 articles. As 643 articles were still too many to sift through, the keywords 'Educational Psychology, Mental Health, UK' were entered into the search engine and this in turn resulted in 59 articles being highlighted. The list below highlights the inclusion/exclusion criteria used:

- Number of articles produced by ERIC = 59
- Number of foreign (non-UK based) articles/research and therefore excluded = 22, remaining articles = 37
- Number of articles which were books and book reviews and therefore excluded = 2, remaining articles = 35
- Number of articles that dealt specifically with particular mental health conditions and therefore excluded = 11, remaining articles = 24
- Number of articles that focused on non-educational psychology issues and therefore excluded = 14, remaining articles = 10
- Number of articles focusing on adolescents rather than children and therefore excluded = 6, remaining articles = 4
- Number of articles dealing with complementary therapies and therefore excluded = 1, remaining articles = 3

The three articles that were included because they met the inclusion criteria set in the final keywords search (that is 'Educational Psychology', 'Mental Health', and 'UK') are: Rothi et al (2008), Dawson and Singh-Dhesi (2010) and Squires (2010)

Rothi et al (2008) in the first part of their paper give different accounts of what the role of the EP is regardless of what professional bodies such as the Association of Educational Psychologists (AEP) and the British Psychological Society (BPS) proclaim that the main role of the EP is. The second part of the paper is dedicated to the research carried out amongst teaching staff in reference to their opinions regarding the role of EPs in relation to supporting them in managing mental health difficulties in school.

In the first part of their paper the Rothi et al (2008) focus on the lack of clarity and guidance EPs have regarding their main roles. They stress that too much of EPs time is dedicated to statutory assessments rather than providing psychological interventions and support when children's special educational needs are first identified.

In addition to this Rothi et al (2008) assert that there should be a distinction made between what is considered to be early intervention and effective intervention. This they add is an issue that EPs need to have a greater understanding of. Once an EP has made contact with a child (early identification/intervention) there needs to be effective monitoring and follow up which will then lead to effective intervention.

Overall the paper is unclear as to what they consider to be the main role of EPs; however, the authors are not alone in this. Aston and Roberts (2006) in their study reported that newly qualified EPs were finding it problematic developing a distinct professional identity different from other child related professionals. The argument put forward here is that, apart from their statutory duties, the role of the EP in many situations can be delivered by and through other professionals and this is mainly because the EP's role at present is unclear. SENCOs, they assert, work within an

area that is traditionally seen as the forte of EPs. The authors further highlight the need for more clarity between the roles of EPs, other applied psychologists and allied professionals. They add that applied professionals such as Clinical Psychologists now routinely engage with children and young people who present with mental health problems and Social Workers have a clearly defined statutory role in working with children who are 'Looked After' by the local authority. In order to add some clarity to the role of the EP Rothi et al (2008) cite the British Psychological Society's definition of the role of the EP:

Professional education psychologists are concerned to support and promote the proper development of young people. In doing so, they work with not just directly with young people but also with their parents and families and with other adults who teach and care for them

(BPS, 2002, p.1)

In general terms this definition suggests that the role of the EP has a systemic base; however, when looked at critically, this definition, it could be argued, is quite simplistic because it does not really encapsulate the range of skills that the role entails. Frederickson et al (2008) give more detail regarding the role of the EP by highlighting the core ideals and modes of practice that are incumbent within it. They emphasise key skills such as observation, interviewing, testing, arriving at a hypothesis and a workable solution which they add, form the foundation of modern EP practice.

Although Rothi et al (2008) call for more clarity around the general role of the EP they are however more concerned about the role of the EP within mental health structures. They claim that EPs are one of the few professionals who are capable of straddling both education and health effectively; however they state that the role of

EPs within mental health structures remains unclear because so little attention is devoted to the issue of mental health within schools. This is a strange assertion because both SEAL and TaMHS make mention of the role of the EP especially within what is considered to be Tier 2 interventions within mental health; however, in their paper, these two recent and relevant initiatives are not mentioned. The authors say that EPs have a Tier 2 mental health role within a 4 Tiered mental health model and add that within their role they can, and should be called upon to contribute to teacher training in mental health related issues. According to the authors, this should become an integral role if EPs are to re-invent themselves within the multi-professional partnerships in which they operate. The authors are also of the opinion that even though EP training is now a three year doctoral programme its overall focus has not substantially changed because It does not include comprehensive education on children's mental health difficulties.

Rothi et al (2008) do not present an analysis of the of the various modules and placements relevant universities adhere to in their training of EPs, furthermore, they also fail to acknowledge that TEPs now come from a myriad of backgrounds which may include may include mental health. The paper does not address the potential opportunities inherent within the doctoral programme; TEPs can now specialise in a number of areas including mental health. Regardless of the notion of specialisation through training the authors emphasise:

While it is important to stress that that EPs are not mental health professionals, their education and psychology background means that they can make valuable contribution to schools where there is a diversity of special educational needs

(Rothi et al, 2008, p.129)

Perhaps it would have been more accurate to assert that EPs are primarily applied psychologists who work with children experiencing a myriad of difficulties in schools in which mental health/EBD may be one of such difficulties and that through CPD, EPs can add specific mental health training to their already wide range of skills and experience.

Rothi et al (2008) in the first part of their paper make only few references to teachers' views of EPs regarding mental health in schools, however; the second part of their paper is dedicated to the research they undertook in this area.

The research undertaken by Rothi et al (2008) relates to 32 (primary, secondary and special) schools out of approximately 100 who agreed to take part. The participants were comprised of teaching staff ranging from teaching assistants to head teachers. Only one member of staff was interviewed from each school which meant that the research was based on the views of 30 participants (two were excluded, one because there was more than one person was in the room when being interviewed and the other, due to the fact that even though he/she had teaching duties he/she was not in a teaching post).

Semi-structured interviews were used to collate the views of teachers regarding their perceptions and experiences of the management of pupils with mental health difficulties in school. Rothi et al (2008) admit that this qualitative approach does not guarantee objective data collection; however, they do add that objectivity was sacrificed for the participants' 'phenomenological reality'. In turn the data were analysed thematically using Interpretive Phenomenological Analysis (IPA). Listed below are the main issues that came out of the analysis:

- Teachers liked the time allocation models EP use in deciding the level of support each school receives during an academic year
- EPs appear to be more reactive than proactive which is akin to fire fighting
- Schools recognise the benefits of EPs being involved in mental health however the support they received from them was few and far between
- The paucity of time EPs spend in schools hampers the potential relationships they could form with school staff. The participants believed that this was due to the high turnover of EP staff
- Teachers feel obliged to exclude certain children with mental health difficulties because of the paucity of support from EPs
- Statutory assessments are time consuming and deflects EPs away from engaging more substantially in mental health issues within schools
- EPs operate a hands off approach and appear more willing to deal with cases via consultation rather than work with the pupils directly
- EPs are useful in identifying pupils experiencing mental health difficulties in school, however; they are not mental health experts and are therefore no substitute for the involvement of actual mental health professionals.

Rothi et al (2008) make clear that even though EPs are valued, there is some confusion regarding what their roles actually entail, especially in the area of mental health. A positive aspect of the research, however; is the large range of schools that it covered which in turn resulted in a wide expression of views being gathered. A limitation of this paper, however; relates to the fact that even though it focuses on the role of the EP, no EPs were actually interviewed. Although the paper's focus was on 'teachers' views and experiences of working with educational psychologists in schools' it would have been appropriate to confirm with EPs, what they thought their

role entails and the difficulties they face in performing it. Doing so would have given the study a multi-faceted perspective and in turn, more robustness and depth.

Dawson and Singh-Dhesi's (2010) paper is divided into three main sections, the first section is an exposition of health, and more specifically what mental health is. In congruence with Rothi et al (2008) they too position the role of the EP within the context of mental health and more notably within schools. The second part of the paper focuses on a piece of research undertaken in the Midlands which is an evaluation of an intervention called the Child Behaviour Intervention Initiative (CBII) which is a mental health resource for children based on the 2008 CAMHS Review. The third part of the paper is dedicated to the setting up of a TaMHS project within Leicestershire.

The first part of the paper as hitherto alluded to, explores the various definitions of mental health; these definitions however, are not explained in isolation but critiqued within the context of the ECM. Dawson and Singh-Dhesi (2010) focus on the 'stay healthy' aspect of ECM and explain that the term 'healthy' within this context covers both physical and mental health. They go on to say that a number of people only consider health as a physical dimension without realising that it concerns the psychological, emotional, intellectual and spiritual aspects as well. The authors state that unless a person is mentally healthy he/she cannot claim to be physically healthy. This alludes to the WHO's (2004) understanding of health which is concerned with both the physical and emotional aspects of health. The authors relate the concepts and definitions of mental health to government initiatives such as TaMHS and in doing so highlight the importance of health to children and young people. CAMHS is also mentioned; they add that children and young people who are referred to resource would already have been seen by Special Educational Needs Support

Services, thereby highlighting that some issues relating to education can also be linked to health and more specifically, mental health. This highlights the importance of timely and effective interventions at a very early stage in order to prevent the escalation of mental ill health later on in children's and young people's lives. It is at the level of early and effective intervention that the authors say that EPs play a vital role. Unlike Rothi et al (2008), the authors do not really question the role of the EP within mental health structures, instead they put forward the case that EPs are most effective within mental health structures when they collaborate with other professionals within multi-agency partnerships.

Dawson and Singh-Deshi (2010) add that the advent of ECM has helped to bring under one place, the traditional child-oriented provisions of education, health and social care departments. Schools are places where children spend the most time after their homes, and in some situations are the best places for them for effective and appropriate socialisation to take place. Due to the fact that schools are now obliged to take on additional roles within the Extended Schools initiative, it could be argued they are now a single point of contact where children are able to access resources from health, educational and social care. The authors claim that due to the way in which schools are now structured, the role of the EP is now invaluable as they are the best placed professionals to understand what is happening to the child both at home and in school:

Educational psychologists are well placed to understand and work in these different settings. They have professional training and function that takes them out of the clinic and places them in schools and the home – the very places where young people are

(Dawson and Singh-Dhesi 2010, p.298)

What Dawson and Singh-Dhesi (2010) do not say however, is what constitutes EP training especially since it is now a three year doctoral programme. Potentially this gives EPs scope to specialise in areas that were not hitherto considered to be the core of EP practice; mental health arguably being one of them. Although mental health is not mentioned specifically, it is implied because they explain that EPs in addition to working in schools incorporate within their practice the understanding that children exist within a web of relationships and so they need to understand children within all these contexts if they are to engage with them effectively.

The second part of the Dawson and Singh-Dhesi's (2010) paper focuses on the evaluation of a particular intervention undertaken in Leicestershire called the CBII, the aims of the intervention are as follows:

- improve the life opportunities of both children and young people
- the provision of locally based support
- engendering a more encompassing understanding of mental health
- creating support for parents based on a social-ecological model
- utilising relevant voluntary organisations
- having a diverse understanding of mental health which is relevant to all and in particular individuals from BME backgrounds.

Although the role of the CBII is to bring together under 'one roof' education, social care, health and the voluntary sector, Dawson and Singh-Dhesi (2010) are of the opinion that schools are best placed to be recipients of early and effective interventions. Pattison and Harris (2006) support this view by stating that schools are prime places for social and emotional development of children to take place. This they assert is because of the holistic overview schools have in addition to their

vantage point within societies. They explain further that because schools are strategically positioned within society it makes them a point of reference and access for parents, agencies, resources and children themselves. This they add, make schools an integral base for early intervention strategies to take place

Gross (2006, cited in the Centre for Social Justice, 2008) confirms that early intervention presents an opportunity to makes access to education equal for all.

Such intervention, the author argues, has the potential to make up for any developmental lag previously experienced. The author cites a study of a cohort of children born in 1970 where it was shown that children who were academically below average at the age of five became high achievers by the age of 10. The reason for this the author believes, reflects the specific and effective interventions the children had access to at the start of their formal education. The importance of early and effective intervention is also emphasised in a recent policy document 'No Health without Mental Health' (DoH, 2011).

Dawson and Singh-Dhesi (2010) acknowledge the difficulties and delays that children and young people generally face in getting referred to CAMHS unlike the CBII which they claim offers quick and careful assessment of the needs of children and their families. The CBII teams consist of a professional from health (CAMHS), social care (Senior Family Support Worker) and education (Assistant EP). The authors emphasised that the Assistant EP took the lead in using Solution Focused Brief Therapy (SFBT) as the therapeutic intervention of choice. SFBT was chosen, they add, not only because it is as effective as other therapeutic interventions but in relation to training, it takes considerably less time for professionals to be competent in it than other therapeutic interventions of the same ilk. The CBII interventions are

group focused and for the purpose of evaluation, the authors focused on four main groups summarised in the list below:

1. Social Growth groups (focused on reducing aggression in pupils)
2. A Transition group focused on vulnerable children moving from primary to secondary school
3. Guided groups focused on Year 5 pupils and worked mainly on their self-esteem
4. Growth Optimum groups (A positive psychology based group focused on passive and pessimistic pupils).

The effectiveness of the CBII interventions were evaluated by Strength and Difficulties Questionnaires (SDQs) completed by parents which showed a significant improvement in their children's self-esteem and behaviour. In their analysis, Dawson and Singh-Dhesi (2010) report that over 60% of parents had seen a positive improvement in their children after interventions. The authors support their use of SDQs by referring to research undertaken by Vogel et al (2009) whose research confirm that SDQs are an appropriate tool to use when exploring mental health difficulties in children.

Dawson and Singh-Dhesi (2010) explain what led up to the setting up of the CBII. When TaMHS was introduced in 2008, the Leicestershire Council was in a good position to bid and be chosen as one of the 25 local authorities in which TaMHS was to be piloted. An important thing to note is that TaMHS in Leicestershire was headed up by a school nurse seconded from the NHS. The other members of the TaMHS team were made up of Family Support Workers and an Assistant EP. Additional support was provided by a Child Psychotherapist and specialist input from CAMHS

(a consultant Child and Adolescent Psychiatrist). Two things are worthy of note in Leicestershire's set up of TaMHS, first was the number of health professionals involved and second was the absence of qualified EPs within the resource. As with the CBII, the authority opted to base TaMHS on the 2008 CAMHS Review although the authors do add that the TaMHS project was based on SEAL, and positive psychology as postulated by Seligman (2008). The overall set up of TaMHS suggests that the role of the EP was not integral to it. Apart from an Assistant EP, the only time qualified EPs were called upon was to do specific work with pupils on resilience and behaviour management; EPs it would seem within this particular TaMHS project were on the periphery of therapeutic interventions.

The situation whereby EPs are not involved in therapeutic interventions brings into question the role of the EP in relation to direct work with children. Mackay (2006) argues that by not working directly and therapeutically with children limits the EP role and denies children what could be said to be an effective resource in alleviating the emotional difficulties facing them at home and within school.

Mackay (2007) points out that in some quarters direct therapeutic work with children and young people is not viewed favourably. Gillham (1978) suggests that this mode of working with children became unpopular due to the EPs overarching focus on academic attainments and testing. Farrell et al (2006) highlighted in their study that schools do value the therapeutic aspect of the EPs role. Most people who responded to their survey said that they valued the contact they had with EPs but also stressed their desire for more work to be done in the area of therapy and intervention.

Farrell et al (2006) add that to a large degree, the role of the EP is defined by their application of psychology when working with children within school and community

settings. A number of respondents in their study commented that EPs' direct work with children within a therapeutic framework was highly valued. What the authors do not address though is how the training of EPs prepares them for the demands of therapeutic work and also how statutory and time constraints potentially impinge upon their chance to undertake this role. Looking at case and school allocation models as well the other roles EPs perform would have given their ideas more clarity. Mackay (2006) also supports the view that EPs should be involved in therapeutic work because of their commitment to working with children in schools working with children in, however; as with the previous authors however, he does not address EP training and how much of it is geared towards therapeutic work with children.

Squires (2010) in his paper, focuses directly on the role of the EP within therapeutic interventions and in particular CBT. Squires says that there are a number of children who have emotional difficulties severe enough to be classed as mental health problems. Such children are in schools yet there are not enough mental health professionals who are able to deliver therapeutic interventions to meet the needs of such children. With regard to therapeutic intervention, the author is referring specifically to CBT and argues that EPs with sufficient training in this therapeutic intervention, although not therapists, should be able to offer CBT to children in schools. A further argument that the author puts forward is that CBT is an intervention that was originally designed and delivered to meet the needs of adults; in its pure/unadulterated form it would have very minimal effect when used with children. It is at the point at which CBT becomes relevant for children that EPs should be involved.

Squires' (2010) stance is an equal and opposite reaction to those who argue that EPs are not qualified therapists and are therefore unable to deliver therapeutic interventions (especially CBT) to children effectively. In arguing for the suitability of EPs in delivering CBT he refers back to EP training and more specifically the old Masters degree programme which although was tightly packed, still covered areas such as basic counselling skills. He adds that the Masters degree programme in itself did not offer a qualification in counselling or CBT but that EPs who were interested in these interventions were able to train in such areas through further training/CPD.

There has been an understanding at policy level in the UK that medication is not the only way to effectively treat people who are experiencing mental ill health (DoH, 2011). This school of thought has coincided with the heightened prominence of psychological therapies which are now being given recognition and value within medical, social and educational services. The British Psychological Society (BPS, 2007) report on psychological interventions addresses this same point and in doing so draws attention to the fact that even though the NICE guidelines recommend specific therapies for people experiencing mental ill health, the implementation of these therapies within clinical practice continues to be a problem for both stakeholders and service providers. The main problem according to the report is the one of supply and demand. The demand for psychological therapies is plentiful but the supply is scant. Jones (2008) in support of this polemic confirms that the NHS faces social, political and economic pressures to provide free healthcare at the point of delivery. When faced with such pressures, all forms of interventions become restricted, including psychological therapies. She adds:

However, currently only a small percentage of service users receive recommended psychological treatment for their mental health problem under current service delivery arrangements. The concept of equal access and choice in Psychology Services and Mental Health Services appears to be even less developed than in other areas of the NHS

(Jones 2008, p.9)

As with Squires (2010), Jones (2008) believes that qualified psychologists are in prime positions to deliver and support a number of psychological/therapeutic interventions. Squires, however takes this view further by specifically referring to mental health services for children and highlights the demand for CBT in light of the paucity of clinic- based therapists who routinely work with children. It is within the discourse of non-medical and alternative interventions that TaMHS was established (DfE, 2011a). Squires takes this argument further and gives six reasons why suitably trained and competent EPs should deliver CBT to children.

1. The NHS has a tiered structure in relation to mental health. Tier 1 which is a universal approach and relates mainly to those who have minor mental health difficulties and can be dealt with by all members of the children's workforce or Tier 1 CAMHS workers. The way in which EPs work and the training they have received enables them to work in between the most minor (Tier 1) and the more complex needs (Tier 4). Children deemed as needing Tier 2 and Tier 3 interventions can have their needs met within SEAL and TaMHS and more importantly, within school. As EPs are applied psychologists best placed to work with children in schools means that they should be able to deliver CBT to such children
2. EPs already have the theoretical and practical knowledge of a number of therapeutic interventions in which CBT is one of them. CBT is quite directive

and involves teaching people new skills and unlearning old and negative ways of thinking and doing things. This makes CBT an invaluable resource for working with EBD children. EPs are skilled in working with EBD children and are able to adapt CBT approaches in order to meet their needs

3. EP training compares quite well when juxtaposed against other relevant professions especially when it comes to training in CBT
4. Children are qualitatively different from adults and are a group who need to be understood in their own right. EPs undertake considerable training in child development and are able to adapt their theoretical knowledge of child development into practice
5. Schools are complex places where children potentially present with complex issues. EPs are conversant and aware of the various levels of complexity within schools and are therefore skilled enough to understand the dynamics at play. Having this overview they are the professionals best placed to decide when and how CBT should be used.
6. EPs have both generic and specific skills which makes them very adaptable within the workplace. Socratic questioning, evidence based practice and the ability to apply psychological theories are all relevant to the delivery of CBT and hence the EPs use of it.

Squires (2010) offers a robust defence of the EPs ability to use CBT with children and within school settings, however, his arguments could be used in the promotion of EPs using other therapeutic interventions, for example, Rogerian based counselling. Focusing on CBT alone in some sense diminishes the other 'tools' and techniques that EPs employ on a regular basis which have been proven to be effective. The author also does not address the fact that just because a person is a qualified

EP does not make him/her competent in using specific therapies. Being competent in using any particular therapy is dependent of training and skill in using them.

2.4 Conclusion

Literature reviews systematic or otherwise are undertaken as matter of course within doctoral level research. This attempt to highlight academic resources directed at answering the research questions.

It should be mentioned at this point that the bibliographic sources examined and reviewed in this chapter do not represent an exhaustive list on any of the themes highlighted but are a sample of the information available.

There are learning points that can be taken from this literature review. At the beginning of the chapter I alluded to the fact that the literature on TaMHS was scant and this limited the number of journal articles that were used. A comparative review/study of therapeutic interventions in other countries, for example, Scandinavian countries would have added more richness to my overall study.

Within this chapter the only therapeutic intervention that was really addressed was CBT. A critique of other therapeutic interventions and the viability of EPs employing them would have added more breadth and depth to the literature review.

Furthermore a literature review focusing on individual therapies such as play therapy and reflexology could also have been undertaken as this would have given the overall chapter a wider perspective.

The articles reviewed highlighted the different methodologies that were used to gather and analyse the views of the participants involved in the various studies

undertaken. A review and evaluations of the different methodologies especially focus groups and the used of SDQs employed in these studies would have given the literature review more of a critical edge and would have added more relevance to the methodology chapter.

Chapter 3

3 The Methodology

3.1 Introduction

This chapter is intended as a brief overview of issues relating to the methodology used in this research. In this chapter the concepts of themes, labels and constructs and how they relate to the methods used are addressed. As this research is wholly realised through qualitative methods there is within it an understanding that the researcher is the link between what is observed, recorded and analysed. The researcher is therefore in a position to observe and analyse phenomena according to the particular point of view he/she may hold. The researcher's perceived subjectivity may therefore be considered a hindrance to objective analysis. A particular problem associated with qualitative research is that of neutrality because every discourse claims to hold the truth. Foucault (1980) argues that as individuals we do not approach social phenomena or inquiry with a *tabula rasa* for we are surrounded and affected by the various discourses at play:

Truth is a thing of the world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its general politics of truth: that is, the types of discourse which it accepts and makes true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true

(Foucault, 1980, p.131)

It could be argued, however; that the identification and diagnosis of such difficulties are based on our own constructions which are further underpinned by particular discourses that permeate our value base and in turn decision making.

Discourse and truth are never neutral, or as Rushdie (1990, p.60) claims: '...for every story there is an anti-story'. As an outsider and supporting no particular perspective within the mental health discourses, I argue that steps have been taken to ensure, as far as it is possible, objectivity within the framework qualitative of research is attained. Through the research questions, the methods employed in this thesis address the constructs of parents, teaching staff⁴ and children. It also expresses the evaluations children have of the therapeutic interventions experienced. The main method used, that is, semi-structured interviews gave the children a medium through which they could discuss their views and experiences of education in a way that other methods could not have done as effectively.

3.2 Epistemological Considerations

Epistemology or the theory of knowledge is a philosophical model concerned with the nature, variety, origins, objects and limits of knowledge. Within academic research there are two main epistemological traditional positions, namely the positivist school of thought and the constructionist school of thought. This research encapsulates the various views and experiences of the participants and because of this their subjective reality has to be addressed and accorded due recognition; this is why the social constructionist approach has been adopted. Regarding this model, Gergen (1985) is of the opinion that a social constructionist enquiry is ultimately concerned with expounding the procedures by which people come to illustrate,

⁴ This includes all members of staff in a teaching role, that is, teachers, SENCos and head teachers but not teaching assistants

espouse or otherwise account for the environment in which they live. Social constructionism expresses and articulates general modes of understanding as they now exist, as they existed in prior bygone times, and as they might exist should creative attention be so directed.

As the social constructionist position challenges perceived wisdom and uncontested edifices of power, its aim within social enquiry is therefore to transform taken for granted discourses. Burr (2008) states further that the psychological and social environments cannot be understood by relying on old practices, assumptions and ideas. A fuller understanding can only be achieved by building into our research new methods of scientific enquiry. This will afford researchers an understanding of how knowledge produced within traditional scientific paradigms is a function of the power imbalance between researchers and the body of study.

An example of the researcher's epistemological position is evidenced in the interviews undertaken with the children who had accessed TaMHS. Some of them were given reflexology as a means of alleviating their mental health symptoms such as anxiety. The interviews revealed that the children were mainly positive about the effects of reflexology and some stated that they felt calmer after the treatment.

Although Pattison and Harris (2006) claim that the evidence base for the effectiveness of holistic therapies such as reflexology in the alleviation of mental health symptoms is scant, the lack of scientific evidence or 'truth' however, does not invalid the commonsense 'truths' of the children. Within social constructionism their truths are not to be discounted because of their lack of scientific knowledge, application or power.

Gergen (1985) believes that social constructionists take up one or more of the four following conditions:

- What is taken to be experience of the world does not in itself dictate the terms by which the world is understood;
- The terms in which the world is understood are social artefacts, products of historically situated interchanges among people;
- The degree to which a given form of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on changes of circumstances of social processes;
- Forms of negotiated understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage.

It could be argued that the four conditions listed above bear some relation to the position taken within critical psychology. In highlighting the link between social constructionism and mainstream psychology, Danzieger (1997) believes that the former functions as a critique of the latter. Burr, in expressing the link between the two schools of thought, adds that the analysis examines the questions that psychology chooses to ask about human endeavour and the approaches it undertakes to explore.

Although this research clearly reflects a social constructionist position there is an inherent understanding within the researcher's thought processes that there is no epistemological position that is without its limitations.

Numerous criticisms have been levelled at constructionist epistemology. Gergen (1985) in his paper highlights the fact that detractors of social constructionism argue

that in the absence of a positivist stance, social constructionism implicitly reduces all phenomena to a relativist ideal and this in effect makes social constructionist's epistemologically weak. In addition to this particular criticism, the author explains that due to the idea that veracity or the concept of truth is socially constructed, it explicitly relegates tried and tested scientific fact as just one explanation amongst a myriad of other 'truths'.

3.3 Ontological Considerations

According to Jary and Jary (1991), ontology relates to the branch of philosophy concerned with the establishment of the fundamental kinds of truths which exist in the world. Closely linked to one's epistemological outlook is the researcher's ontological stance reflected in the thesis. The research undertaken in this thesis is underpinned by the ontological paradigm of relativism, that is, an understanding that phenomenon is governed by a myriad of perspectives and through a process of critical reasoning such myriads of thoughts and perspectives must be admitted into one's ontological reasoning. This is in direct opposition to the positivist approach. As the authors explain, the main strand of the positivist approach is the expectation that scientific knowledge would invariably, through the application of logically interrelated general propositions based on scientific principles, result in the emergence of truths or facts. The problem with this approach is that it excludes all other interpretations of phenomena which are not based on scientific application. This approach therefore does not fit in well with relativism which rejects the idea of a single truth in relation to specific phenomena.

This research therefore alludes to the fact that rather than there being just one (scientific) truth, there are in fact a myriad of truths and so there is no such thing as

an objective reality. As the researcher's epistemological position is a social constructionist one it therefore fits into the relativist paradigm because it is imperative that all truths should be considered.

3.4 Research Paradigm

Methodology within research is not a simple or straight-forward process of showing how information was collected and disseminated; it goes deeper than that. According to Doyle (2003), the foremost issue to settle when undertaking research is the establishment of the research paradigm. Aveyard (2007) explains that research paradigms make clear the researcher's set of beliefs and practices. The research paradigm sets out the researcher's value base and dominant discourses that permeate his/her thoughts and beliefs.

When undertaking social research it is imperative that the most appropriate of the three main approaches available to the researcher is selected. The three approaches are quantitative, qualitative and mixed methods.

3.4.1 Quantitative Research Methods (The Positivist/Pragmatic Approach)

The quantitative or positivist approach uses numerical data in making large scale generalisations and in doing so seeks objectivity and detachment from its subject matter. According to Mertens (2005), quantitative research is concerned with formality and objectivity within systematic processes which are then used to obtain a statistical understanding of the world, population or sample size.

Aveyard (2007) expresses the view that quantitative research is seen to be appropriate when it is required to be interpreted numerically and when underlying and specific trends need to be identified. This method is best employed in cases

where a high number of participants are involved in a survey or the data set includes a high volume of variables:

Quantitative research sometimes referred to as positivist research, uses experimental methods and/or methods that involve the use of numbers in the collection of data. Traditionally there is no involvement between the researcher and participant and the researcher stands metaphorically 'behind a glass screen' to conduct his/her research

(Aveyard, 2007, p.25)

Quantitative research has statistical relevance in considering whether a piece of research is reliable and valid. Its strength lies in the fact that when conducted properly it is expected that another researcher undertaking the same experiment or research will attain the same conclusions. The statistical robustness and validity of quantitative research is an element that qualitative research does not have.

Due to the relatively low numbers of participants interviewed and the information sought, that is, individuals' constructions of mental health - it was thought that quantitative approaches would not be appropriate in this research. It was for this same reason that a mixed method approach was not considered to be beneficial for the purpose of this research.

It should be noted that there are quantitative methods that are relevant when only a relatively small number of participants are involved; single case design experiments being one such method. This approach is useful when the research is aimed at individual performance outcomes rather than group performance outcomes. Within my research the individual constructions held by the participants had already been revealed during the interviews together with the children's views about TaMHS therapeutic interventions. Single case design experiments, in my opinion, would not

have been as effective in analysing the rich stories that the participants had to tell compared with the qualitative approach that I chose to adopt.

3.4.2 Qualitative Research Methods (The Interpretive or Relativist Approach)

According to Willig (2001), a qualitative approach within social research has a propensity towards meaning and how people make sense of the world and the immediate environments around them. Pope et al (2007) further explain that such an approach is termed interpretive because the approach centres on an empathetic understanding of meaning and is therefore directed towards generating a new conceptual understanding of theoretical explanations. In this research, for example, this approach was effective because it revealed qualitative data about the respondents' constructions of mental health, and offered the children the opportunity to evaluate their experiences of therapeutic interventions accessed through TaMHS.

Although qualitative research lacks the statistical robustness of quantitative research, its aims are very different. Qualitative research is not necessarily interested in statistical analysis but in the richness of participants' experience. Experience, it could be argued, is not objective; however, it is the subjectivity of people's experiences that makes qualitative methods worthwhile. Regarding qualitative methods, Aveyard (2007) explains that qualitative data are often collected through the interpretations, accounts and verbal descriptions of those participating in the research rather than by numerical facts and the resultant interpretations which is the mainstay of quantitative approaches. Qualitative approaches therefore employ methods such as in-depth interviews as the main type of data collection as this allows meaning through exploration of the topic with the research participants to be made.

Qualitative research is often criticised because of its inability to be replicated and, more often than not, the participant selection tends not to be random. Another criticism of this type of research is that unlike quantitative methods, qualitative methods are not reliable. Reber (1985) counters this assumption by saying that the attributes of qualitative methods makes redundant the arguments relating to its reliability. In addition, the author says, reliability is a generic term used to illustrate the dependability of a measurement device or test. Within quantitative research dependability equates to consistency which in turn means the degree to which the measurement device or test yields the same approximate results when utilised repeatedly under similar directions. The author further explains that In qualitative research, dependability is not necessary because the researcher is more interested in the individual rich pictures the participants create rather than the uniformity and potential replication of each picture.

The strength of qualitative research, however, is its ability to investigate ideas within ecologically valid contexts. The importance of validity within qualitative methods cannot be over-emphasised. Validity in qualitative research is not simply a matter of the exact findings being relevant to the research questions; the issue of good practice is central. Tindall (2002), in explaining the term, says that validity is an integral element. It has to do with the aptitude and acumen of the researcher to make known and represent other people's interpretations. Validity therefore becomes the quality of the knower- in relation to his/her data and developed by different vantage points and forms of knowing. It is, then, personal, relational and contextual.

Aveyard (2007) asserts that another dimension for opting for a qualitative approach is because it also lends itself to phenomenology whereby through in-depth interviews

participants have the opportunity to explore and describe their lived experiences within the interview setting. As a purpose of this research focuses on understanding the constructions people have of mental health outside the realm of those who are mental health professionals and experts themselves, it was felt that a qualitative approach was more appropriate. Such an approach focuses on the rich and lived experiences of the participants collated from interviews rather than statistical analysis. It must also be stressed that the decision to include children in the study introduced a power dimension to the research. As hitherto stated, children were interviewed in order to encapsulate their experiences in schools in a way that will enable their views to be considered within the competing discourses of parents and professionals. This process is however, problematic for the researcher. France (2004) stresses that the researcher has the power to influence the presentation of views by the design of the questions asked:

It is impossible to separate out the voice of the researcher- given that they have selected the topic, designed the questions and constructed the final report. To see 'giving a voice' as a valueless project is to deny the politics of doing research

(France, 2004, p.179)

France (2004) explains further that it is important to consider other perspectives if greater depth within the research is to be engendered:

Others may also have important contributions to make, for example, parents and professionals may have an alternative perspective that adds to our understanding of the broader social and cultural processes that help shape and impact upon the lives of young people

(France, 2004, p.179)

Bringing children into the research paradigm was not taken lightly due to their potentially vulnerable status; first because of their age (they were all primary school pupils) and second, their situation (they were deemed to have experienced some degree of emotional difficulty). Giving them a voice and thereby empowering them to evaluate their own experiences of TaMHS served two main purposes: (1) it validated their views because no one had done so in my local authority prior to this research being undertaken (2) it made them the focus of the research and therefore the researcher's dependency on their cooperation minimised the power dynamics between the researcher and the participants. Tindall (2002) acknowledges the power of the researcher and the importance of reducing it; she advises that the focus should be to minimise the power differential and to employ active participation within the process to the extent that we can ensure that there is no exploitation.

Ladd (2003) gives a very stark account of the power differential between the interviewer and participants, especially when the latter are children and states that the traditional structures within academia are characterised by a privileged subject investigating an underprivileged object.

Giving children a free reign to talk about their experiences hopefully minimises the chance of such gap in the power relationship from happening.

3.4.3 Mixed Methods (The Critical Realist Approach)

Critical realism is predicated on the assumption that empiricism alone cannot bring about a more accurate understanding of the social world. In order to gain a better understanding of social phenomena, both empirical and relative approaches are needed. May (1997) explains:

If researchers content themselves with studying everyday social life, such as conversations and interactions between people, this will distract them from an investigation of the underlying mechanisms which make them possible in the first instance

(May, 1997, p.12)

This approach as alluded to in the title is relevant to research which adopts a mixed methods approach as both the qualitative and quantitative data are considered within it. As my research is based on qualitative methods only I cannot say that I have adopted a critical realist approach.

3.5 Triangulation

Pope et al (2007) explain that triangulation is commonly employed as a reason for using a mix of methods in social research. They also add that because triangulation is used in so many different ways it has become stripped of meaning. Its origin, they explain is in navigation where two observations of landmarks are used to plot a third location. Tindall (2002) mentions that the importance of triangulation within research cannot be over emphasised:

Triangulations allows illumination from multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience. Traditionally there has often been the reliance on one method of data collection and analysis. We need to recognise that all researchers, perspectives and methods are value laden, biased, limited as well as illuminated by their framework, particular focus and blind spots. Triangulation makes use of combinations of methods, investigators, perspectives etc., thus facilitating richer and potentially more valid interpretations

(Tindall 2002, p.145)

Triangulation in the strict sense of the term was not used in this research because it implies that the researcher has used a mixed methods approach. For the purpose of this research, only one method was used, that is semi-structured interviews. A triangulation of participants' views is therefore a more accurate way to describe how the data was collected and analysed.

Cohen and Manion (1980) explain that the over-dependence on a particular method of data collection and interpretation will invariably distort the overall picture. As this research focuses on competing perspectives and constructs, using one method to collect data may potentially result in one perspective being discussed more fully to the exclusion of the other. Being aware of this, care was taken to ensure that each participant was interviewed separately and the information gathered individually, thereby ensuring that each person's account was afforded the same level of attention.

Cohen and Manion (1980) claim that it is not unsurprising that a great deal of research has employed specific approaches or procedures out of methodological parochialism or ethnocentrism. Some researchers, they say, have the propensity to champion particular and favoured methods because those are the only ones they have familiarity with, or they are of the opinion that their approaches and procedures are superior to others. The rationale for using thematic analysis and within it semi-structured interviews was based on the fact that this presented the best approach even though other qualitative methods such as discourse analysis could have been used. It should also be added that this was the first time that I had used thematic analysis.

When employing mainly qualitative methods there is the possibility that the researcher becomes too close to his/her data thereby fostering an academic narrow-mindedness in the analysis of the data collected. Cohen and Manion (1980) suggest the use of 'investigator triangulation', a method whereby more than one participant or observer is used for the purpose of greater objectivity and validity. They add:

Perhaps the greatest use of investigator triangulation centres around validity rather than reliability checks. More to the point, investigators with differing perspectives or paradigmatic biases may be used to check out the extent of divergence in the data each collects. Under such conditions, if data divergence is minimal, then one may feel more confident in the data's validity. On the other hand, if their data is significantly different, then one has an idea as to the possible sources of biased measurement which should be further investigated

(Cohen and Manion, 1980, p.122)

Within my local authority another trainee/doctoral student had also been commissioned to do an evaluative study of TaMHS but from the perspective of teachers. We checked each other's data and interview questions and also interpretation and understanding of academic material to ensure that we became each other's 'investigator'.

The Process of Data Collection

3.6 Stage 1 (Locating Relevant Schools)

As mentioned in the first chapter, TaMHS began as a three year pathfinders project piloted in 25 areas in England; my local authority being one of the participating authorities. Not every school in the local area was a recipient of TaMHS; in fact, of the 104 primary school in the local authority, only 11 schools were involved in the

project. Of the 11 schools, 10 were based in two main localities - the North and the Peninsula.

To understand the various constructions people have of mental health I needed to locate a rich sample size and so the search for participants was focused on the North and the Peninsula. The names of the schools highlighted in the table below are pseudonyms.

Table 3.1 Participation Schools/Number of Children Accessing TaMHS 3

Participating Schools	No. of children	Percentage
Sparrow Primary	9	9%
Robin Primary	8	8%
Owl	3	3%
Kiwi Primary	22	22%
Swallow Junior	6	6%
Thrush Primary	7	7%
Penguin Junior	12	12%
King Fisher Primary	7	7%
Stork Infants	11	11%
Hen Primary	5	5%
Canary Primary	11	11%

In the research proposal I indicated that six children would be interviewed; gender and age were not stipulated, however it, was imperative that the therapies/therapeutic interventions available would be spread among the pupils represented within the interview sample. It was proposed that two of the participants would have accessed play and or art therapy, another two, counselling and the

remaining two, reflexology. Of the six children I interviewed, five were boys and only one was a girl. This is not an exact reflection of the gender spread within TaMHS as a whole but the intricacies of research where one is dependent on the permission and cooperation of others regarding who could be interviewed. Of the 101 children in the local authority who took part in TaMHS, 66% were boys and 34% were girls.

As TaMHS in the local authority is primary school focused all the children who accessed the various therapies were under the age of 12. As the table below illustrates, the age band between 7 to 10 had the highest concentration of children accessing the various therapies.

Table 3.2 The Age Range of Children receiving TaMHS 4

Age	Total	Percentage
4	2	2%
5	8	8%
6	9	9%
7	20	20%
8	21	21%
9	16	16%
10	17	17%
11	8	8%

Rather than contact all the schools involved in TaMHS, the criteria for excluding certain schools were two-fold: (1) schools that had already been accessed by the other trainee/doctoral student. These schools were excluded because having two research projects taking place simultaneously would have demanded too much of

the particular schools' resources (2) schools that had not responded favourably to requests from previous trainees/doctoral students regarding their research.

At the end of the exclusion and hence inclusion process, three schools were chosen. One of the schools happened to be in the patch of schools (Hen School) I was responsible for. After speaking to the head teacher she confirmed that four pupils were relevant to my study, however only one pupil took part in the interview. In January 2011 my research had to be halted because therapists delivering therapeutic interventions under the auspices of TaMHS had objected to my research. After a number of meetings I was given the go ahead (in April 2011) to recommence my research, however, I lost an extra two months of research time during this process.

The fact that my research had been delayed due to ethical clearance and opposition from therapists within TaMHS made it imperative that the schools chosen thereafter would be willing for me to conduct research on their premises as time was of the essence.

The second school (Sparrow School) involved in my research was made possible by my line manager. This school was within my line manager's patch of schools. My line manager made contact with the head teacher regarding my research who subsequently agreed that her school could be used for the purposes of my study.

Getting a third school to agree to my research was very problematic. I did not have the time to contact other schools partaking in TaMHS and so I had to approach a school that my colleague had already used in her research thereby going against an exclusion criterion I had set. The head teacher of the particular school (Robin

School) was willing for me to conduct my research at her school even though my colleague had used it for her research.

Stage 2

3.6.1 Contacting Schools and Parents through Letters

At the point of asking schools to partake in my research and the fact that time was of the essence, I was no longer overly concerned whether the sample of pupils provided an extensive enough range of therapeutic interventions/therapies available within TaMHS. At this point it was important to ensure that enough pupils were available to be interviewed. The following processes took place:

- All three schools were sent letters asking if they were willing to be participants in my research. The letters also highlighted the fact that further permission/consent would be needed from the parents and the children themselves (see Appendix 2);
- Letters were sent to the parents via the schools requesting their consent regarding their children taking part in the research (see Appendix 3);
- After receiving consent from the parents a further letter was sent to them enquiring whether they too would like to partake in the research (see Appendix 4).

Stage 3

3.6.2 Narratives and Interviews

The main reason for opting for a qualitative approach and more specifically interviews relates to the fact that in order to access their rich narratives, interviewees potentially need to be coaxed via the skill of the interviewer in the form of the

questions posed (Edward and Talbot, 1997). Using a narrative approach meant that the views of the pupils interviewed would be presented over the competing perspectives and constructs that some adults have of them. The parents of the children interviewed also had the chance to talk about their own constructions of mental health in relation to their children. As teachers were also interviewed, they too had a chance to discuss their views in relation to their constructions of mental health. The interview/narrative approach ultimately locates power in the narrator. Burman (2002) is of the opinion that this approach empowers people because it values what individual participants have to say about the questions posed to them. Within this process the author adds that the process of interviewing participants is seen as a collaborative exercise because it promotes responsibility on the part of the researcher to be accountable to, and in some cases to conduct research agendas according to the demands of the participants. The dynamics of power which traditionally favours the interviewer is re-balanced as the researcher strives to carry out research in non-exploitative, non-dehumanising ways.

Nelson (2004) says that via this process, children are able to reconstruct their histories thereby affirming a sense of identity. This is because what they say to the interviewer is considered to be valid data - their own discourses. Daiute (2004) emphasises the importance of listening to the narratives of children and young people within the interview process because of their potential to be autobiographical.

By constructing their own stories, people, regardless of the discourses that define them, are able to see things from their own perspective. Burr (2008) introduces the aspect of agency within narratives; she argues that in our attempts to represent ourselves in particular ways, we are dependent on the willingness of others to allow us to paint a picture of their part in the action that suits our story. The author's

postulation, however assumes that the agent is looking for some sort of congruency and affirmation from the person who is listening to the narrative or story. Narratives within interviews need not conform to the perceived ideas and ideals of the interviewer. Agents operating within the paradigm of interviews need to be free to relay their stories as they see it and not seek the confirmation of the interviewer for some degree of validation.

3.6.3 Interviews

The importance of interviews within qualitative research cannot be over-emphasised as they are the most efficient and effective way of collating people's views and thoughts about specific and topical issues. The attraction of interviews is the fact that it promotes a dialogue between the interviewer and the respondent, thereby forging a two-way process. Edwards and Talbot (1997) are of the opinion that, if conducted properly, interviews encourage the views and voices of the participants to be heard which, in turn, directs the evaluation and interpretation of events. The authors are of the opinion that conducting interviews in the right way is imperative if the overall research is to be successful. They add that while poor questionnaires may produce useful data, a poor interview is of little use.

It could be further argued that interviews do not always cover every eventuality. Humberman and Miles (2002) emphasise the point that even though interviews may be well conducted they are not infallible, for they are only as effective as the participants' contributions. Interviews, they add, may be descriptively, interpretively, and theoretically valid as an account of the person's actions and perspectives but invariably may miss other aspects of the person's perspective that were not

expressed in the interview. This, the authors believe, can easily lead to false inferences about the participants' actions outside the interview situation.

Interviews within qualitative research can take two forms: structured and semi-structured interviews. The rationale for using one or the other depends on the research questions that need to be answered or the issues to be investigated.

3.6.4 Structured (Closed) Interviews

An advantage of structured interviews according to Taylor and Bogdan (1984) is that the questions are the same for all participants and so their responses may be compared favourably with each other. This means that quantifiable data can be collated and also replicated thereby ensuring reliability.

In highlighting the advantages of structured interviews the Open University Research Handbook (2001) adds:

Because closed questions limit the range of possible answers, analysing the information you collect is much easier than when people give a variety of answers to each question. This can be important if you have to interview a large number of people

(OU, 2001, p.271)

A limitation of structured interviews, however, is the notion that the questions posed will mean the same thing to all respondents. Denzin (1995) explains that the purpose of structured interviews is to encapsulate and extract data of a codable nature in order to explain behaviour within pre-established categories. The problem here is the inflexibility of such interviews. It could be argued that structured interviews are best used when eliciting information from adults who are competent, confident and open in their communication. Children and young people who are shy and not very

confident communicators may find being exposed to such a model rather daunting and unsatisfying.

3.6.5 Semi-Structured (Open-Ended) Interviews

In contrast to structured interviews, semi-structured interviews give the interviewer and the respondent greater flexibility in answering questions. As it can be seen in Appendix 8 a wholly semi-structured approach was employed with all the participants. Within this paradigm participants are not restricted in the answers they give because of the flexibility inherent within this approach. Another important aspect of semi-structured interviews is that the interviewer is able to import a degree of reflexivity within the questions asked. This approach gives the respondents a degree of autonomy and hence power within the interview process to say as little or as much as they want.

Another apparent advantage of semi-structured interviews is that it lends itself to modification, which in itself is a reflexive process. Within the structure of semi-structured interviews the interviewer may alter the original questions or pose one which is not actually in the interview schedule. This is done when further information and clarification is needed. In interviewing all the participants as a part of this research, additional questions and the modification of questions were employed in order to obtain the information needed. This is evidenced in Appendix 8 where the questions asked in the interviews differed slightly from the ones written down.

Semi-structured interviews are not without its limitations. Gillham (2002), for example, highlights the issue of time. As more questions are likely to be posed within this process, the interviewer needs to be mindful that respondents may not have the time to answer all the questions. This became apparent when interviewing the six

children as part of the TaMHS evaluation. I was only able to interview the children during their lunch break which in itself is very time-restricted.

After weighing up the pros and cons of both structured and semi-structured interviews a decision was made to adopt the latter mainly because a degree of flexibility is needed when conducting interviews with children or adults who are not expansive in their descriptions.

3.6.6 Interview Formulation

When planning interviews Edwards and Talbot (1997) advise a seven stage process; this process was employed when devising the interview questions used in this research. The seven stages are as follows:

1. Writing the initial interview questions on a sheet of paper.
2. Brainstorm the question areas on to the paper.
3. Group the brainstormed questions into coherent themes
4. Arrange the questions thematically starting with the least intrusive first and the more intrusive questions towards the end.
5. Drawing on brainstorming, start to write the questions that allow the interviewer to explore the themes that need to be drawn out of the interviewees' responses. This usually means employing open-ended questions.
6. Arrange the questions to be asked in a coherent order starting first with descriptive questions like, 'What is your name?' and ending with factual questions like 'Can you tell me how you felt about being referred to a play therapist.
7. Always end with a positive question.

Edwards and Talbot (1997) also advise on good conduct when undertaking interviews:

1. Arrange sufficient time for the interview. It should be noted here that this piece of advice assumes that the interviewer is in control of the interview schedule. When it came to interviewing the head teachers and the pupils it had to be done at a time convenient for them. The time slot given was usually during the lunch break and after they had eaten their lunch.
2. When interviewing busy professionals a form or payment may be necessary. I did not offer money but I did offer to give each school a copy of the completed thesis once it has been passed by the examiners.
3. The use of a quiet room is imperative.
4. Ensure that reliable and high quality data voice recorders are used. For the purpose of this research 'Audacity' was used which records straight on to the computer being used.
5. Have an ergonomic chair and a desk or table at a convenient height.
6. Assure confidentiality and stress the need for detailed and full responses to the questions asked.
7. Keep a balance between conversational tone and the need to control the direction of the interview.
8. Leave plenty of time for responses and do not feel the need to continually fill silences.
9. End the interview if the respondents are showing signs of distress.
10. Do not be put off by inconsistencies but instead clarify issues that have not been made clear.

Much has been said about the use of interviews within qualitative research and the way in which they were used within this particular thesis. What also needs to be added is the fact that other methods of data collection were considered alongside interviews before semi-structured interviews were deemed the most effective and efficient method to employ. Two methods in particular were considered, namely focused groups and participant observation.

3.6.7 Focus Groups

A problem with face to face interviews is that the interviewer ideally can only interview one person at a time, which in itself is very time consuming. I would have preferred to have arranged a group meeting with the pupils to discuss their experiences of mental health and TaMHS therapeutic interventions, in other words, focus groups would have been ideal. Breakwell et al (1995) explain focus groups as discussion based interviews that produce a specific type of qualitative data:

The 'focusing' component of focus group research - that is, its distinguishing characteristic- refers to the concrete and specific character of discussion in relation to a particular stimulus object, event or situation

(Breakwell, et al 1995, p.277-8)

This method of data generation would have benefited the overall purpose of this research. As my role would have been that of a relatively passive facilitator, the pupils would have been empowered to control the content and direction of their discussions. This would have reduced the power differential between me, the researcher and the respondents. At the same time there needs to be an awareness of the potential of dominant pupils eclipsing the voices and views of those who are not that confident in group situations. This would mean the potential for only a limited part of the groups' rich stories being heard, thereby skewing the information

collected. Focus groups therefore do not guarantee that everyone get an equal chance to participate fully.

Focus groups are also contingent of having a critical mass of people to make such a process viable. In one of my schools (Hen School) I only had one pupil to interview and so the focus group approach would not have been a viable option.

3.6.8 Participant Observation

Participant observation is akin to imbedding oneself within the data to be collected. It compels the researcher to be part of the group to the extent that she/he is no longer viewed as an outsider by the people from whom the data is to be collected. Maanen (2002) explains that participant observation is an ethnographic approach that is commonly used within social anthropology and adds that it allows a fieldworker to use the culture of the setting to account for the observed patterns of human activity.

Breakwell et al (1995) have reservations concerning this approach because it potentially compromises the researcher's objectivity due to the fact that observations will be subjected to fluctuations in the attention. Furthermore, the considerable personal demands made on the researcher by the dual role of researcher and participant encourages the possibility of role conflict.

Participant observation is best employed within long term anthropological projects which require the observer to understand particular cultures from within. Given the limited time of this research and the particular ways in which schools are structured, employing participant observation would not have been an effective or efficient way of collecting data.

3.6.9 Questionnaires

The use of questionnaires was considered because it represents an effective means through which information can be gathered and analysed. Aveyard (2007) confirms this point and adds that they can be used effectively in both quantitative and qualitative research. As I only had 12 participants in my research it would have been inexpedient to use questionnaires as a medium through which numerical analysis could be made. Although the use of questionnaires may have been of some benefit to my research, the disadvantages of using them outweighed the potential benefits. Oppenheim (1992) comments that the return/completion rate for questionnaires is often poor; furthermore, through this medium it is not often possible to get access to representative samples. Questionnaires also depend on a degree of literacy. As I had no prior knowledge of the children who be taking part in my research I could not assess their levels of literacy and thus the suitability of using questionnaires with them.

Stage 4

3.7 Data Analysis

According to Okely (1994), in order to carry out data analysis effectively, the researcher needs to be fully immersed within the whole process:

Data analysis is not only a cerebral activity – it involves the whole person. No matter how systematic and stringent the analysis strategy employed, important insights and discoveries may be made by chance, or in situations or contexts seemingly removed from the daily task and detailed work of coding and analysis

(Okley, 1994, p.21)

The table below represents the original interview schedule⁵:

Table 3.3 Interview Schedule for Parents 5

Parent	Child	Date
P1	Pp1	21/01/11
P2	Pp2	25/01/11
P3	Pp6	27/04/11

Table 3.4 Interview Schedule for Pupils 6

Pupil	School	Date
Pp1	Sparrow	21/1/11
Pp2	Sparrow	25/1/11
Pp3	Robin	27/03/11
Pp4	Robin	17/03/11
Pp5	Robin	17/03/11
Pp6	Hen	27/04/11

Table 3.5 Interview Schedule for Teaching Staff 7

HT / SENCO	School	Date
HT/S 1	Sparrow	21/01/11
HT/S 2	Robin	17/03/11
HT/S 3	Hen	27/04/11

Three parents, six pupils and three head teachers/SENCO were interviewed in order to collect data in relation to their constructs and understanding of mental health.

Additional data was required from the pupils interviewed in relation to their experience of being referred to TaMHS and their overall views of the interventions

⁵ The dates were later changed due to the delays experienced with the data collection

they had accessed. The collection of data via semi-structured interviews or any other methods within the qualitative and quantitative approaches would be superfluous if there were not strategies put in place to analyse the information collated. For this reason thematic analysis was deemed the most appropriate qualitative tool to employ in order to make sense of the data collected.

3.7.1 The Rationale for Employing Thematic Analysis

Pope et al (1997) give a detailed definition and explanation of what thematic analysis entails and the ideal situations in which it can be used. They surmise that thematic analysis is one of the most common methods used within the applied social sciences. It comprises the identification of the main, recurrent or most important issues or themes arising within a body of evidence. The authors add that this method is used in identifying, grouping and summarising findings in 'first generation' literature reviews and is commonly used in the early stages of a narrative synthesis.

Pope et al (1997) explain further that such an approach to the analysis of data is aimed at working with and reflecting directly the main ideas, constructs and conclusions of data samples in which prominent themes become apparent.

Thematic analysis is particularly popular amongst EPs undertaking doctoral research; however, this is not the main reason why this method was preferred over other analytical approaches. Braun and Clark (2006) are of the opinion that unlike other analytical approaches such as discourse analysis, content analysis and grounded theory, thematic analysis does not require the detailed theoretical knowledge of the aforementioned approaches. Furthermore, thematic analysis is considered a very flexible analytical tool as it is not entrenched within a particular

epistemological approach. The flexibility and non-aligned nature of thematic analysis fits in well with the interpretive disposition of this research.

Thematic analysis was also chosen because it ties in with the interpretive/relativist approach to qualitative research methods and also to the epistemological position taken in this thesis that is, – social constructionism. Although thematic analysis is not bound to any one epistemological position, Tuckett (1995) argues that thematic analysis can be informed by social constructionism in that the different constructs people have about a particular phenomenon are in fact themes. If the data to be analysed highlights differences in the constructions of mental health that parents, teachers and pupils have, these differences, to all intent and purpose are themes.

It needs to be highlighted here that thematic analysis was only opted for after juxtaposing it with other comparable approaches. It was only after this that they were discarded in favour of thematic analysis. The other approaches were discourse analysis, content analysis, grounded theory and Interpretive Phenomenological Approach (IPA).

3.7.2 Discourse Analysis

Discourse analysis is defined by Denzin (1995) as a text based analysis that includes print, visual and audio-visual material available for reading, viewing, or hearing. The author notes that these mediums create texts which in turn form a body of work which is then interpreted and interacted with. The meaning of the text according to Denzin is indeterminate, open-ended and interactional.

While texts did inform part of this research overall the discourses pertaining to mental health were not the main artefacts to be analysed. The purpose of this

research centres on people's own constructs of mental health and not the analysis of what had been written hitherto.

3.7.3 Content Analysis

Content analysis was another approach considered. Edwards and Talbot (1997) explain and define this approach as an analysis of mainly textual information:

Content analysis was developed for primary research on a wide variety of mainly textual information but it can be used to synthesise findings from published research to identify dominant findings and, thereby, make generalisations

(Edward and Talbot, 1997, p.48)

In common with discarding discourse analysis as an effective means of analysing the data collected obtained from the interviews, it was thought that content analysis is much very text based and a wholly descriptive process which does not necessary offer an enquiry into the underlying motives for certain constructs and behaviour.

3.7.4 Grounded Theory

Grounded theory works well as a process of induction because it allows the data collected to act as a catalyst for the theorisation of concepts and original thought. In some way it grounded theory can inform a thematic approach. Orona (2002) in explaining grounded theory states that this approach is not linear because it allows for the materialisation and emergence of concepts through the data collected. It is a schema that allows for in depth self-observation, examination and intuition within social research.

There is a latent danger with grounded theory that the researcher may be tempted to analyse phenomena to the point of over-analysis. A main reason for not using

grounded theory lies in the fact that within this research a main focus was the experiences of children in mental health paradigms and not necessarily the theories created as a result of the data collected from the interviews.

3.7.5 Interpretative Phenomenological Approach (IPA)

IPA explores how phenomena relate to individual experiences. Larkin et al (2006) explain that this approach involves very detailed accounts from a relatively small number of participants. The precise accounts can be gleaned through mediums such as diaries, interviews and focus groups. Through such data patterns are developed and meaning derived

Although IPA is a viable option to thematic analysis, I was not certain that the pupils I intended to interview would have provided me with enough detail in which to analyse. Furthermore, my focus on social constructionism meant that in my opinion thematic analysis appeared to be a better option.

3.7.6 Other Qualitative Approaches

I am aware that there are other relevant qualitative research methods that I could have considered for this research. These include Cooperative Enquiry, Personal Construct Approaches and Action Theory. Due to the time constraints I felt that the approach I eventually chose was the most effective in terms of time and application.

3.7.7 Exclusion Criteria

It should be added here that the decision not to use discourse analysis, content analysis, grounded theory, IPA or the other qualitative approaches highlighted in this section was based mainly on the 'best fit' model for the purposes of this research and not because they lack analytical rigour or credibility.

3.8 Thematic Analysis at a Level of Induction

Once the choice has been made to employ thematic analysis a decision must be made whether the process of analysis will be an inductive or a deductive one. For the purposes of this research analysis occurred at a level of induction because its main aim was to locate emerging themes from the data collected. Thematic analysis at the level of induction within this research meant that the narratives of the participants and the subsequent codes generated expressed the evaluative perspective purpose of this thesis.

A further reason of using thematic analysis at the 'level of induction' relates to the fact that within an evaluative paradigm is the importance of the interpretations of the emerging codes. Braun and Clark (2006) comment that codes provide a clear sense of the scope and diversity of each theme, using a combination of analyst narrative and illustrative data extracts. Where relevant they broaden their analysis out, moving from a descriptive to an interpretive level.

3.8.1 Stages of Thematic Analysis

The research followed the six staged model of thematic analysis advised Braun and Clarke (2006) illustrated in the diagram below

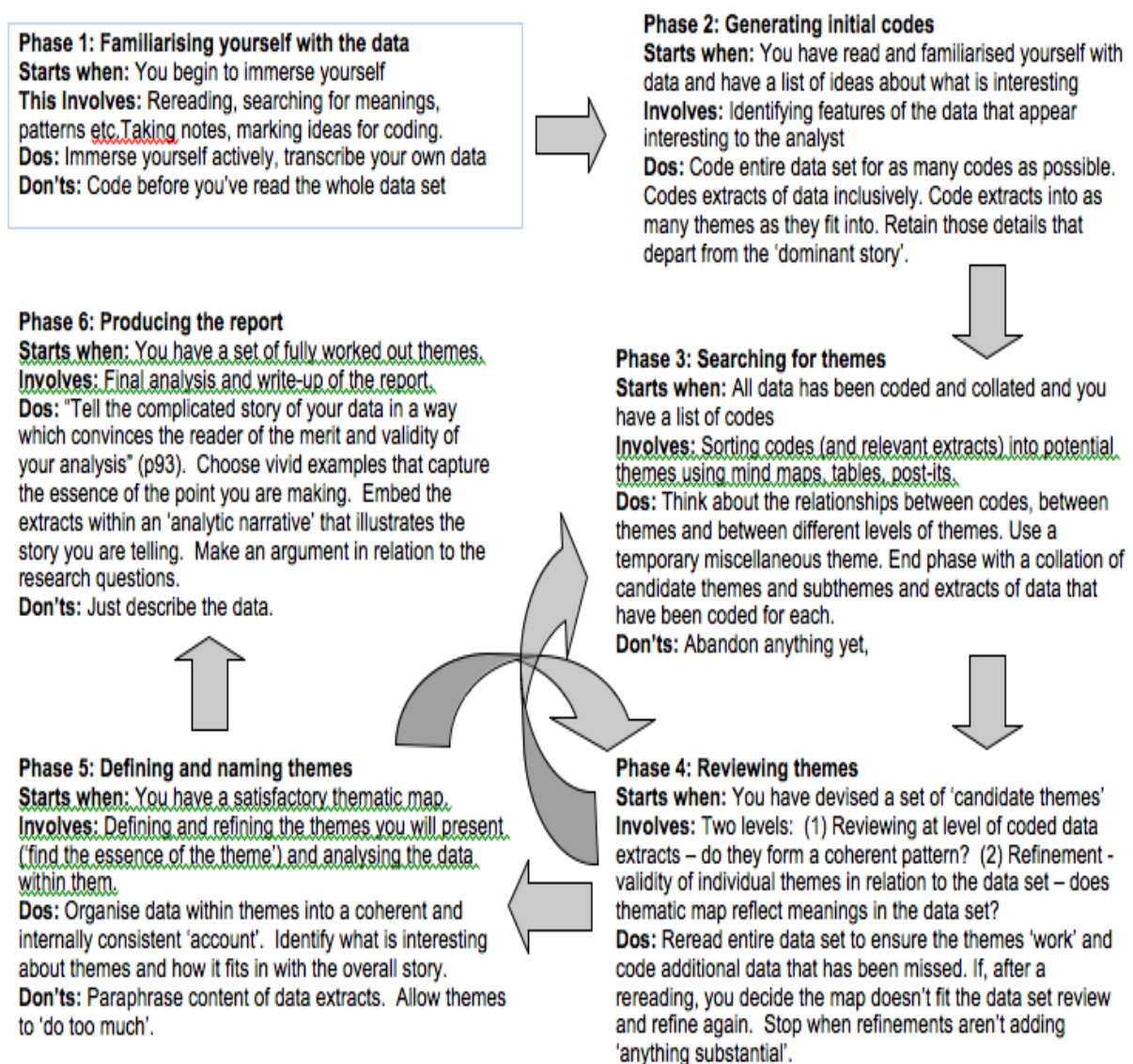


Figure 3.1 Stages of Thematic Analysis 4

3.8.2 Stage 1: Familiarisation with the data

The reading and re-reading of the interview transcripts is advised in order for the researcher to become conversant with the material so that initial thoughts regarding the data can be made. In other words the researcher becomes immersed in the data.

In explaining what immersion Braun and Clark (2006) state:

Immersion usually involves repeated reading of the data and reading the data in an active way – searching for meanings, patterns and so on. It is ideal to read through the entire data set at least once before you begin your coding as

ideas and identification of possible patterns will be shaped by what you read through

(Braun and Clark, 2006, p.87)

I read the interviews scripts a number of times before I could really say that I fully understood what each participants was really saying

3.8.3 Stage 2: Generating initial codes

Codes, themes and sub-themes were generated manually with the most obvious themes being included and the irrelevant ones being discarded. The relevant sub-themes were underlined and translated into themes. An example of a system of coding I used is highlighted in the text and table below.

Data Extract

'J'...he is a Year 6 boy; he did not come to us until the beginning of Year 5. He is very quiet. He has ADHD. He has individual support from TaMHS. He comes from a very disaffected family. His sister has ASD and he is almost withdrawn so he almost doesn't get noticed because he doesn't do anything that will draw attention to him, down to is work He gives you the opinion that that he's quite capable but underneath he's really not

(Head Teacher, Robin School)

Table 3.7 Analysis of Themes and Sub-Themes 8

Sub-theme	Theme
Boy	Gender
Year 5	National Curriculum Year
Very quiet	Behaviour
Support	Access to TAMHS

ADHD	Comorbidity
Disaffected Family	Family Situation
ASD	Sibling
Almost withdrawn	Emotional State
Doesn't get noticed	Quest for Normality
Draw attention	Quest for Normality
Quite capable	Quest for Normality
Underneath he's really not	Actual Situation

According to Braun and Clark (2006) a theme is a segment of text that has relevance to the overall research. It represents a level of congruency across a number of respondents. At this point nearly every segment of text was coded because it was not yet possible to deem which ones were relevant and those that were not.

3.8.4 Stage 3: Searching for themes

This stage only happens after all the data have been initially coded. At this stage discrimination into potential themes and how the different codes relate to one another takes place. This was the most interesting part of the thematic analysis process. For each interview, every segment of information that was thought to be of relevance was underlined. After this was done the interviews were collated into their individual data sets and compared with each other. Through this process congruent themes and sub-themes started to emerge; extracts of relevant texts were then underlined and their line numbers within the script noted. At this point segments of information that I thought were not relevant to the interview were discarded through the process of not underlining the text and ascribing them sub-themes. A table was

then created showing how the underlined segments of texts became sub-themes and then themes (see Appendix 6).

3.8.5 Stage 4: Reviewing themes

This stage involved the reviewing of themes ensuring that they were correctly named and clustered. This also involved reviewing themes that were altogether not very clear without understanding the context in which the statements were made, for example, a parent I interviewed made the following comments:

Things were getting very hairy at home so you have to think if the grief you're getting is going to spill over into something unpleasant. I'd seen things like this spill over before so we legged it.

Without knowing the context in which statement was made, finding a code for it would have been difficult. As I understood the context in which it was said it was coded under family strife and displacement.

3.8.6 Stage 5: Defining and naming themes

Important information from the transcribed data was extrapolated as a means of justifying the existence of each theme. Each theme is thought to be a segment of a bigger picture or story or as Braun and Clark (2006) explain:

For each individual them, you need to conduct and write a detailed analysis. As well as identifying the story that each theme tells, it is important to consider how it fits into the broader overall story that you are telling about your data, in relation to the research question or questions to ensure there is not too much overlap.

(Braun and Clark, 2006, p.93)

The identification, coding and inclusion of a theme was not done on the basis of the number of times a keyword, term or issue appeared within a text but on whether a theme was thought to be central to the research questions and to the overall qualitative approach of this thesis

3.8.7 Stage 6: Producing the report

The thematic analysis of 12 semi-structured interviews resulted in 18 themes being created amongst the participant groups. The themes are as follows:

Parent themes

1. Family Situation
2. Parents' Appreciation of Difficulties
3. The Role of the School
4. Mental Health Constructions

Teaching Staff themes

1. Location of School
2. Socio-economic Factors
3. Family Situation
4. The Role of School
5. The Role of Teachers
6. Labelling
7. Comorbidity
8. Anxiety
9. The Impact of TaMHS
10. TaMHS to Continue

Pupil themes

1. Family Situation
2. Attitude towards School
3. Types of Therapy
4. Effects of Therapy

These themes are discussed fully and individually in the next chapter.

3.9 Thematic Analysis – a critique

Braun and Clark (2006) admit that thematic analysis as a qualitative method used in understanding and analysing data is poorly demarcated even though its use is widespread. Tuckett (1995) highlights the fact that many who purport to have employed thematic analysis within their research have done so without really detailing exactly how the process of systematically analysing the data was done. In the previous section I have set out a step by step approach of how the data was collected and coded.

It is apparent from the literature on thematic analysis (Tuckett 1995; Braun and Clark 2006) that this method is based on the interpretations, preconceptions and the particular constructs that a researcher might have. In order to minimise the effect of my own constructs and ideas on the data collected, I gave the data to my fellow doctoral/trainee colleague who took on the role of 'rater'. The rater generated themes that were very much similar to mine thereby ensuring validity within the whole process.

3.10 Ethical Issues

Before I was permitted to undertake this research I had to go through a very stringent process which included the research proposal being assessed by the UEL tutors before it being deemed satisfactory. Afterwards the University of East London's Ethics Committee had to sanction the research proposal. After the Research Committee had sanctioned the proposal the same process had to be followed with the Local Authority's Ethics Committee (see Appendix 1). It took both Ethics Committees eight months between them to sanction the proposal. It was not that the intended research was considered contentious in any way but the fact that further information was required from me even though what was required was clearly stated in the proposal. In the proposal it was clearly stated that that pupils from selected primary schools would be interviewed. UEL Ethics Committee asked if by 'schools' I meant 'the School of Psychology'. The local authority on the other hand asked if I intended to pay the parents who had agreed to become participants in my study, even though no such arrangement had been highlighted in the proposal. Inevitably this caused a considerable delay in searching for suitable participants.

This research set out to strictly adhere to the guidelines and standards of the BPS's Code of Ethics (BPS, 2006). Before interviewing the participants they were all informed that they were free to withdraw from the interview process at any time without fear of recrimination. This was stressed quite strongly with the children. In selecting the participants, I stressed to the parents and the head teachers/SENCo that only the children they felt were robust enough to be interviewed should be put forward. I was open and transparent about the fact that I would be asking the children to talk about the difficulties they had experienced at home and in school. After each interview the children were debriefed and thanked for their participation.

All the participants were informed that their identities would remain confidential. The participants were also informed that within the interview transcripts their real names would not be revealed. This level of transparency was needed in order for the researcher's professional integrity to be maintained. This issue is stressed by Hitchcock and Hughes (1989) who add that an ethical researcher should always be very clear about the aims and objectives of the research to be undertaken.

In order to comply with the Data Protection Act 1998 and more specifically the management of audio files, the following steps were taken to ensure that the recordings of the participants remained confidential:

- Following transcription all the audio files on my computer were deleted
- The names of the participants were changed
- Other names mentioned in the interviews were deleted

Despite having had clearance from two Ethics Committees my research faced opposition from the TaMHS therapists to the extent that I had to cease collecting data for two months. The TaMHS therapists had a number of concerns about me becoming involved in TaMHS, these concerns were focused mainly on the grounds that I had not obtained ethical clearance from their ethical committee and the fact that they were unsure as to how effectively I could respond to children who became distressed during the interviews (see Appendix 7).

In response to the therapists' objections to my research, the University of East London's Educational and Child Psychology Programme Director and my Academic Tutor sent the local authority's Principal Educational Psychologist (JM) a letter detailing the ethical processes that I had gone through thereby making my proposed research valid (Appendix 7).

All the issues raised by the TaMHS therapists were responded to by JM, the local authority's Principal Educational Psychologist (PEP) who confirmed that it was the local authority who had 'commissioned' me to undertake the TaMHS research and that I had obtained the necessary ethical clearance from the local authority. My original plan was to undertake research in the area of drugs and alcohol misuse among teenagers, the PEP, however, decided that TaMHS research would be more beneficial to the EPS. Before I was allowed to re-start my research two meetings were held between the EPS and representatives from Onside⁶ who were also TaMHS therapists. The issues highlighted within these meetings revealed the potential professional tensions between EPs and the therapists, the latter believing that the former are not sufficiently/specifically trained enough to offer therapeutic interventions. At the end of the last meeting attended by representatives from the university the TaMHS therapists were satisfied that due process had been followed

3.11 Conclusion

When undertaking research especially one of a qualitative nature it should not be assumed that the process will be linear and with no interruptions. From the delay by the various Ethical Committees to the temporary cessation of my research, a high level of patience, fortitude and resilience was needed on my part. At times it felt that the research in itself was no longer worthwhile due to the level of opposition faced. Another perspective would be to suggest that such an experience enables the researcher to be both reflective and reflexive and perhaps this is the reason why the research was eventually completed. Opting to undertake qualitative research was based on the understanding that I would be able to gather rich data relating to participants' views, perspectives and constructs. In doing so the views, perspectives

⁶ A therapeutic resource for secondary school pupils in the local authority

and constructs of therapists regarding the role of the EP unexpectedly formed part of my research which in retrospect added to the quality of the research.

These are not the only ethical issues to be considered. On reflection, the letters I wrote to the parents and the explanation of my research to the pupils including the subject of confidentiality could have been made clearer. These issues are dealt with in greater detail in the following chapter under 'Reflective Analysis'.

Other learning points derived from my experience of planning research relate to the fact that I could have involved more professionals in the study. It could be argued that had I included the TaMHS therapist from the onset I may not have faced such stringent opposition to it. Including the TaMHS therapists would have engendered a better understanding between their roles and the role of the EP.

Chapter 4

4 The Research Findings

4.1 Introduction

A significant reason for adopting a wholly qualitative approach was to ensure that the participants who were interviewed were enabled to tell their own stories in their own words thereby creating a rich narrative of perspectives and constructs relating to the idea of mental health. Burr (2008) expands on this view:

Human beings are fundamentally storytellers who experience themselves and their lives in narratives terms. Perspectives that see the person in relational, dialogic or narrative terms see the person as a co-production, constructed during interaction or other symbolic dialogue. Within all of these views it is possible to regard personal agency as actual or as an effect of and constituted in language

(Burr, 2008, p.147-148)

As mentioned in the previous chapter, semi-structured interviews were employed in order to understand the participants' constructions of mental health and also children's views of the therapeutic interventions they accessed through TaMHS. This chapter provides an overview of the research findings for each of the three groups of participants interviewed, namely: (1) parents (2) teaching staff (3) pupils. The three groups of participants were asked questions in order to elicit specific information. The parents were asked question aimed at understanding the difficulties their children had experienced and also the constructions they had in relation to mental health. The teaching staff were also asked questions aimed at understanding their constructions of mental health and in particular the peculiar behaviours observed in

some pupils which resulted in referrals to TaMHS. The pupils were asked questions aimed at exploring the difficulties they had experienced both at home and in school with an additional emphasis on the therapies they were able to access and their evaluation of these therapies.

Each group was initially coded separately into the three main groups mentioned above, that is, (1) parents (2) teaching staff (3) pupils. Congruency of codes, sub-themes and themes were sought within each group. The process as highlighted in Appendix 6 shows how segments of the interview texts were categorised into codes, sub-themes and then themes congruent codes between the groups.

4.2 Participant Information

Apart from locating the relevant schools, I took no part in selecting which child or parent to interview. The head teachers/SENCo selected the children and parents who were to be interviewed. The information below relates to the number of participants I interviewed:

Twelve participants were interviewed: parents (3), head teachers/SENCo (3) and pupils (6).

Six children were interviewed. They were all in mainstream primary schools and aged between eight and eleven.

Three primary schools participated in the research:

(1) Sparrow Primary School – two pupils (Year 6)

(2) Robin Primary School – three pupils (Years 4, 5 and 6)

(3) Hen Primary School – one pupil (Year 5)

- None of the pupils had a Statement of Special Educational Needs and were therefore all in mainstream schools
- All the participants were white and from England thereby reflecting the general demography of the area
- Three mothers were interviewed as none of the fathers were available

The head teachers/SENCo knew each of their pupils well enough and were instrumental in referring them to TaMHS for additional support, and in turn, interviewed for the purpose of this research.

4.3 Respondent Validity

A criticism levelled at a number of research projects employing solely qualitative methods is their paucity or lack of validity which is sometimes taken to mean a lack of rigour. Although issue of validity was covered in the previous chapter, it is apt to point out that within this research extra steps were taken to ensure respondent validity. Respondent validity is also known as testimonial validity and, according to Hammersely (1998), it is a process whereby the researcher presents to his/her respondents an account of the interview(s) conducted for their validation. Within this process the respondents are given the opportunity to confirm or question the ways in which their ideas and perspectives have been relayed by the researcher, thereby ensuring accuracy and reducing the possibility of research(er) bias. I presented the teaching staff with my overall findings and more specifically their own contributions to the research. They all confirmed that what I had written was a true reflection of what I had said.

4.4 Reflective Analysis

The decision to interview both parents and their children was not taken lightly because I knew that in order to understand the parents' reasons for allowing their children to access TaMHS, and the children's evaluation of the therapies experienced, I would need to ask questions which took them back to a point of emotional turmoil in their lives. For this reason I decided that the best people to advise on the potential participants to interview would be the teaching staff who knew both the parents and their children well enough, and who also could comment on their emotional robustness and suitability for the research project. The BPS Code of Ethics (2006, p.12) states that psychologists should:

Ensure that clients, particularly children and vulnerable adults, are given ample opportunity to understand the nature, purpose, and anticipated consequences of any professional service or research participation, so that they may give informed consent to the extent that their capabilities allow

(BPS, 2006, p.12)

Although the ethical considerations were outlined in the previous chapter it should be noted that every participant knew when they were going to be interviewed and this was relevant for the children especially. The reason for this was in order for the pupils to be monitored closely after the interviews just in case there was an adverse change in their presentation/behaviour. If there was a change in their behaviour I had arranged with the teaching staff to offer the children a short debriefing session afterwards. The interviews with the children themselves therefore involved me taking on a reflexive role. The Open University Research Handbook (2001) states that:

Open-ended questions often work best. Decide what questions you would like to ask in advance, but don't stick too rigidly to them once the child gets going.

Making the child feel that you are listening and responding to his her questions is more important than sticking to the schedule

(OU, 2001, p.173)

It can be seen in my interviews with the pupils (Appendices 6 and 8) that I often discussed non-related topics such as films, computer games and football just to put them at ease.

In the pupil interviews there was an attempt made to explain the confidentiality. I state that: 'What you tell me will remain private. No one will know what you have told me'. This is a very obvious mistake on my part because the confidentiality clause does not cover conversations where a child has disclosed harm and/or the potential of harm happening. The local authority has stringent safeguarding principles based on the Children Act 2004. Had any of the pupils disclosed that they were being harmed or were placed in potentially harmful situations I would have reported it to the head teacher. In explaining the confidentiality clause to the pupils I should have added the exceptions to the rule. I can confirm, however; that no disclosures of harm were made.

The parents were more confident and forthcoming during the interviews and so I did not feel the need to deviate too far from the original script but I was aware and sensitive enough to change my approach if I needed to.

On reflection my letter to the parents asking for their consent to interview their children could be construed as being misleading. The letter could have been worded better. In the letter I state that '...no sensitive or potentially upsetting information will be sought'. What I should have made much clearer in the letter was that the questions that were to be asked during the interview would not require the children to

reveal directly the conversations that took place between themselves and their therapists because doing so would be more potentially upsetting. It would also be apt to point out that what happens during client/therapist sessions is confidential. I was more interested in the types of therapies accessed and if the children understood what happened during these sessions, for example, one of the children (L, from Robin School) was able to explain that during his reflexology sessions different 'flavoured creams' were applied to his feet. Children's mental health and their access to therapy is a very sensitive issue and so my letter to the parents should have stated that their children's access to TaMHS is in itself is a sensitive matter but as the interviewer I would make sure that the way in which the interview is conducted would take cognisance of this fact and if I felt that the child was becoming distressed the interview would be stopped. The issue of sensitivity was however addressed in the script read out to the parents before the interview started where the purpose of my research was made clearer (Appendix 8).

When interviewing the participants they could all see that what they were saying was being digitally being recorded. The issue of the recording and transcription however was never made apparent in the letters or the interview scripts. The process of transcription should have been explained to them. I had intended to do all the interview transcriptions myself but due to the pressure of time I employed the use of a third party transcription service on the advice of a colleague who had used the same service for her research. Six of the twelve interviews were transcribed by the service and all the files were deleted on receipt of the transcriptions.

4.5 Detail of Codes and Themes

The analyses of the semi-structured interviews undertaken with the three aforementioned groups are as follows: Parents, Teaching Staff, and Pupils.

4.5.1 Parent Interviews

As mentioned above three parents were interviewed. An analysis of their interviews resulted in the emergence of four congruent themes. There are similarities between the four themes listed below but because of their subtle differences I decided to separate them into their component entities. The four themes are listed below:

1. Family Situation
2. Parent's Appreciation of Difficulties
- 3 .The Role of School
- 4 .Mental Health Constructions.

4.5.2 Parent Theme 1: Family Situation

Primary school aged children spend the majority of their time at home and in school and so both places, it could be said, are inextricably linked. It is therefore not surprising that what happens at home may invariably affect the child at school and vice versa. The 'Family Situation' was a theme common in the three parent interviews undertaken even though their individual stories and experiences were different. The common denominator, however, was the fact that their children's emotional well- being had, according to them, been adversely affected, be it because of issues emanating from the home which affected their children in school, or issues arising from school which affected their children's behaviour at home. Below are

extracts from the interviews with parents which accentuate the point being made here:

B was very upset when his friend died. At first I failed to realise how much this affected him...I mean how much his friend's death would have on him. There was a school assembly where all the kids could say their 'goodbyes' and I thought that after a week or two he'll get over it. He didn't. He became more and more within himself but any time I asked him if things were alright he'd say 'yes'. I then realised that he started becoming obsessed with death. He was scared anytime I went out - thinking I wouldn't return. He started asking questions like if I was going to die or grandma was going to die to the point that he started seeing death everywhere and in everything

(Parent of B)

I suppose I have to take some responsibility for what G saw at home. It's not right for children to see their mum and dad quarrelling and fighting. I should've left a long time ago and not made my children go through hell. When we left London and moved to... I didn't know that he would get into so much bother. At the time teachers just thought he was a bad kid but I knew inside that the way he was behaving was because of what he saw at home and his friends he was missing

(Parent of G)

You could say that the problems...has started at home. Things were quite difficult; me and his dad split up and I think it was quite difficult for him. At first he was having contact with his dad and then it all stopped. He felt that I had stopped him from seeing his dad but that was just not true. Our divorce became messy and I think he thought he would punish me by not seeing the kids. He was quite close to his dad;

one day we are all living together as a family, then we split up and then all of a sudden he isn't seeing his dad any more. I think it was all too much of an upheaval for him

(Parent of J)

Comment

This was perhaps the most revealing of all the themes and arguably the most important. This theme also links directly or indirectly with the other main themes highlighted within this chapter. The family situation highlights the importance of the social ecological dimension which underpins the theoretical dimension of this thesis. According to this perspective the two immediate loci of support for children are first the family and then the school. The interviews with the parents highlight the school/home interface and their own understanding of the need for the home to be a safe place for their children. It is clear from the interviews that the homes in which they lived were not ideal places for their children's emotional well-being to thrive.

4.5.3 Theme 2: Parents' Appreciation of Difficulty

At first this appears to be a very obvious theme because the parents were asked in the interviews why they thought their children were referred to TaMHS. TaMHS is a specialist resource and so children had to have a discernible problem in terms of their emotional well-being before they could access the therapeutic interventions available. A commonality in all the responses from the parents interviewed was the realisation that even though they wanted to protect their children from the emotional difficulties they were facing, extra help was needed in order to do so:

I was more concerned about my son getting the help he needs...In terms of his problems I think that it was the family break up that caused his problems but I

wouldn't say he had mental problems, it was more family emotional problems if you get what I mean. I would have accepted any help at the time because I was having problems of me own

(Parent of J)

I've had to come into school many times because my lad was getting into a lot of trouble and I've had to talk to people like you. I mean professional types of people to see how my son could be helped

(Parent of B)

Comment

What became clear during the interviews I conducted with the parents was the sense of responsibility they had regarding the welfare of their children. They tried to come up with explanations for their children's behaviour and then seek help in order for these difficulties to be addressed. There was the realisation that their children's difficulties needed to be addressed by people other than themselves. It was this appreciation of their children's emotional difficulties that provided the catalyst for them to first of all engage with their children's respective schools which in turn led to their children being able to access the therapies on offer.

The interviews also reveal how the parents constructed the difficulties their children were having in their own words. These lay explanations were sufficient enough in making the respective schools aware of the difficulties they were trying to describe.

4.5.4 Theme 3: The Role of the School

In the literature review chapter of this thesis is an exposition on the traditional and current roles of schools in relation to the emotional well-being of children. The

discussion that follows highlights the fact that regardless of whether teaching staff feel equipped enough to develop expertise and competence in this mental health they are now required to address this issue within schools. There is now an expectation that there is a dialogue between the school and the home if the emotional well-being of children is to be adequately addressed. The interviews undertaken with the parents exemplify this interaction between themselves and the schools regarding the emotional difficulties their children were going through:

Mrs...asked if I could have a chat with her in her office about my son's behaviour and how the school can help him. First of all I thought she was going to tell me about all the bad things G was getting up to in school but this time she told me about the help she could give...

(Parent of G)

When I spoke to his teacher she said that she had seen some changes in his behaviour; he wasn't being naughty or lippy in class, he just didn't seem himself. It was after this that we were told that sort of therapies were available...

(Parent of B)

Comment

The interview extracts above have congruency with the two previous themes discussed; they reflect the importance of schools, not just in terms of learning but also as places where children's behaviour can be monitored and then fed back to the parents. The previous theme highlights parent's appreciation of the difficulties their children were experiencing while this theme underlines the teaching staff as conduits of information between the parents and the schools.

An alternative explanation is to stress that the current remit of schools is so wide that they are now required to take on more of a parenting role which results in significant demands being placed on them especially when it comes to addressing the holistic needs of the children.

4.5.5 Theme 4: Mental Health Constructions

This theme is closely related to 'Labelling' which is discussed later in the chapter. It was clear from the interviews that communication between the parents and the various schools was exacerbated by the fact that the parents could no longer manage their children behaviour at home. In order to seek help from the school they explained the problems their children were going through in very specific terms. The way they used language, it could be argued, was aimed at getting help for their children:

I know he was going through some emotional problems at the time. He has had problems before like when his dog died he was very upset but he was able to talk to me about it but his sadness didn't last that long. When the kid in his school died his problems were more than when his dog died, he kinda went in to himself and none of us could get him out of it...it's like he didn't want to be with us anymore...

(Parent of B)

Emotional health, self esteem and even mental health all mean the same thing; it means that something is going on in your head and in your heart and so help is needed

(Parent of G)

Comment

Within the parent interviews there is some understanding that issues relating to mental health difficulties do not happen within a vacuum. The parents acknowledged that the family situation was not ideal and that this had exacerbated their children's difficulties both at home and in school. The parents interviewed highlighted a link between problems at home and the difficulties experienced by their children at school. Although they do not possess the specialist or professional language in order to pinpoint exactly and accurately what was wrong with their children, for example, acute anxiety or PTSD, they were however, able to describe what their children were experiencing in lieu of an exact construct or label. Language is important to the idea of social constructionism because it is through this social artefact that meaning is derived.

Interviewing the parents gave them the time and space to explore the reasons why they thought their children were able to access TaMHS therapies. In doing so they were able to able to construct their own stories which became reasons for the problems their children were facing and why they needed help.

4.6 Teaching Staff Interviews

Three members of the teaching staff (two head teachers and a SENCo representing the three different schools) were interviewed for the purpose of this research. An analysis of the interviews resulted in 10 congruent themes emerging. Similar to the parent interviews there are some themes that are closely related with each other and could therefore have been discussed under one heading, for example, the location of the school, socio-economic factors, family situation and the role of the school. I

decided to discuss them separately in order to highlight the subtle differences within them.

4.6.1 Theme 1: Location of the School

The location of each of the three schools that were able to access TaMHS was very important. TaMHS in my local authority was based in the two most economically deprived areas; the Peninsula and the North. The premise for this relates to the premise that mental health difficulties are most prevalent in areas of high deprivation. It should be noted that poverty is relative to its immediate surrounding areas. The local authority within which these schools are based forms part of a larger county which is quite affluent and so it could be argued that poverty in this sense is relative. It can therefore be surmised that poverty in one area of the country does not necessarily correlate with poverty in a different part:

As you may well know we are the poorest area in...and with it comes its own peculiar issues. Many of our children live in homes that are on or just above the poverty line

(SENCo, Sparrow School)

We are a very rural school in the Peninsula. We are an elementary primary school; most of our pupils are from the local village, although we have about 20% of the pupils who come from further afield

(Head Teacher, Robin School)

Comment

According to the teaching staff interviewed, their schools were conveniently and strategically based from which TaMHS could be accessed by the children who were in most need of it. Invariably if there schools were not based within the two

aforementioned areas regardless of the poverty experienced by individual families the children would not have been able to access TaMHS therapeutic interventions. Conversely, this also means that if there were poor families located in areas not covered by TaMHS then the children would not have been able to access the resource.

4.6.2 Theme 2: Socio-Economic Factors

The theme, socio-economic factors is closely related to the previous theme. The subtle difference between the two themes is that the 'Location of the School' relates more to how the schools were chosen and in turn were able to access TaMHS, while 'Socio-Economic Factors' relates more to families and the prevalence of mental health difficulties within them. The interview extracts below reveal the thoughts of the teaching staff regarding the link between socio-economic (and other themes subsequently discussed in this section) and the emotional difficulties of particular children in their schools:

Public transport and things is not good. A high percentage of one parent families...I think a lot of it is to do with the rural deprivation. I think, especially where you've got one- parent families, they're on handouts, so there's not a lot of money. So, everything is very tight

(Head Teacher Hen School)

Many of our parents are unemployed and we have a very high incidence of one parent families. I use the term one parent families very loosely because a more accurate term is single mum families

(SENCo, Sparrow School)

...further afield but still from the Peninsula, mostly home owners. Families, most of which at least one of their parents work. And I suppose you are to describe us as a bit leafy glade, rural, middle class. And we only have one family from a different culture

(Head Teacher, Robin School)

Comment

Although the decision to base TaMHS in the Peninsula and the North was because of factors relating to socio-economic deprivation and its link to mental health problems it appears that not all the schools used for the purpose of this research faced similar levels of poverty. The head teacher of Robin School describes the area in which her school is located as being relatively wealthy indicated a pocket of affluence within a wider socio. It should then be made clear that it is not only the children from lower socio-economic backgrounds that are at risk of mental ill health as children from other backgrounds are also be vulnerable but are not highlighted as much within the dominate discourses. In the full transcript of the interviews (Appendix 8) it can be seen that even though all the children were not from similar backgrounds or had experienced the same issues and home or within the school they still had requirements that needed to be addressed by therapeutic interventions via TaMHS.

4.6.3 Theme 3: Family Situation

Arguably this was the most revealing of all the themes in this section and perhaps the most important. This theme is common in all the interviews highlighted within this chapter. The family situation of all the six children was a significant factor in them being referred to TaMHS. Four of the six children had experienced some form of

family breakup which in some cases included domestic violence, complicated and bitter divorce, and also fleeing from the family home. In other words, the children's emotional well-being was adversely affected by factors within the family home and also in school which in it could be argued, influenced their teachers' construction of their emotional well-being. The interview extracts below highlight this specific point:

...but where do you exclude them to? Back home where the problems started from in the first place? These children can't cope because their parents can't help them because they have issues of their own to cope with. Such children tend to have low self-esteem and have no strong friendship groups

(SENCo, Sparrow School)

A lot of our children feel over-burdened with responsibility, for example, being worried about their mothers who have been subjected to domestic violence which they too have witnessed. I don't think that such children have the resilience to cope with what they have witnessed

(SENCo, Sparrow School)

...and the problems associated with that, for example, neglect and some and so disclosure of abuse from people

(Head Teacher, Robin School)

With our families we've had bereavements, very close bereavements, we have the parents who have died, two mothers have died of very young children at the school. We've had split marriages, adoption, looked after children. And the problems associated with that, for example, neglect and some disclosures of abuse from peoples. And I think that's probably about all, if not more.

(Head Teacher, Robin School)

Comment

What is clearly portrayed in these interviews is that fact that there are a myriad of factors that can cause strain and stress within the family. Difficulties within the family including domestic violence, abuse bereavement are not dependent on background or socio-economic status. What is of particular interest, especially in relation Sparrow and Hen Schools, is that the teaching staff commented on the burden or responsibility in relation to transactional analysis. It would appear that in some situations within the family home there is role confusion between parent and child. Within normative family dynamics it is expected that the parent assumes responsibility for the child and not vice versa. Comments like 'a lot of our children feel over-burdened with responsibility' and 'these children can't cope because their parents can't cope' appears to suggest that the children in question are being exposed to situations in which overwhelmed them suggesting that they are taking on more responsibility than they are capable of. It should be emphasised here that in certain situations, no matter how caring or responsible parents are they cannot always shield their children from every eventuality. The death of close family members is one such example.

4.6.4 Theme 4: The Role of the School

Within the SEAL, Healthy Schools and Extended Schools paradigms, it could be argued that the way in which schools are now seen to operate, places them in a role that extends far beyond their traditional role of teaching. The interviews with the teaching staff revealed that their schools were seen as being more than citadels of learning. Apart from being places of learning, parents approached the school for

advice and guidance regarding the management of their children's behaviour. The teaching staff interviewed appear to suggest that schools are places where the holistic needs of children and their families can be met. The school, it appears, are metaphorically at the centre of their respective communities:

There's an awful lot of children that, when you go home - even in the dark in the winter - they'll be out playing. I think it's a quiet life a lot of time. There's nothing to do out here. There is a village hall, there is a small church, but that's it. The school really almost is the hub of the community. So, when we do things, yeah, that's full. But the rest of the time, the children wander.

(Head Teacher, Hen School)

Yes, I think so. We have a Home School Support Worker as well, which the school also employs. The reason I employed her was because of that, parents - as you say - splitting up, or one parent families having problems with the rent and this and that. So they'd come to us and say "Help, what can we do?" Which is why we employ a home school support worker who does an awful lot of that work for us

(Head Teacher, Hen School)

In an ideal world we'd have everything in school. Wouldn't we?..Everything happens in school

(Head Teacher, Robin School)

Comment

From the interviews with the teaching staff it was clear that schools are at the forefront of extending service to children and families beyond just teaching; there seems to be an acceptance that they need to work more systemically if they are to

address the needs of both children and their families. This view confirms what was mentioned earlier regarding the importance of the location of schools within the parameters set by TaMHS. Not only do the schools represent a physical hub within the community it is also a base from which outreach work is undertaken, for example, the head teacher of Hen School employed a Home School Support Worker to engage with families who were experiencing domestic problems. The role of the school is however, seems to be at odds with the role of teachers as expressed in the next theme.

4.6.5 Theme 5: The Role of Teachers

Although I interviewed the same three teaching staff there is a paradigm shift between what they consider to be the role of schools and what they consider to be the role of teachers. A common thread among the teaching staff I interviewed was the fact that they did not feel that their role that the specific role of teaching did not extent to the care of children presenting with mental health difficulties, however; it is an area they have become accustom to:

The primary job of teachers is teaching but for children to learn their emotional and social needs have to be secure. There needs to be more children centres to cope with these needs. We as teachers cannot provide that extra emotional support that they need because first, we do not have the time and second, we do not have the training. Most of our staff after their degrees went on a one year PGCE course. Do you know how much time was devoted to mental health in schools? One lesson if you were lucky. Now I do not object to teachers becoming involved in mental health but they have to be supported with substantial training and a reduced workload because you cannot not teach and care at the same time.

(SENCo of Sparrow School)

I think you pick up things almost by chance...especially the more experienced members of staff

(Head Teacher, Hen School)

Comment

Just as the role of schools have been extended so has the role of the teacher. In other words, an Extended Schools policy cannot exist without extending the role of the teachers. In the interview excerpt the SENCo of Sparrow School alludes to the fact the role of teachers should be limited to teaching because of the paucity of training and experience in the area of mental health in schools. Teacher training according to the SENCo is not aimed at addressing mental health needs within the classroom and is therefore not detailed or rigorous enough to equip teachers with this extra dimension required of them. Conversely, the head teacher appears to be saying that teachers become more competent in dealing with such issues through experience. So on the one hand the SENCo is saying that more training is needed and on the other hand the head teacher is saying that experience breeds competency in this area.

4.6.6 Theme 6: Labelling

So far it has been established that teachers need more training and expertise as they are now required to work more intently with vulnerable children in school. It could be argued that even though teachers are not trained specifically in mental health, through the process of observation within the classroom and having prior knowledge of certain children's backgrounds, for example, children who are in receipt of free school meals or known to social care, they were, however; able to

refer children to TaMHS via the Vulnerable Children's Register (VCR) or the Child Protection Register (CPR). Teachers, despite them not being experts in mental health are able to label certain behaviours in children as being of concern. Having a label is a tacit indication of a problem or an additional educational need. It is an acknowledgement on the part of teachers that pupils are having problems significant enough to affect their emotional well-being at home and within the school. The importance of such registers cannot be over-emphasised. Without an appropriate label children cannot be placed on the registers, and without their names being on the registers they could not access TaMHS therapeutic interventions. Incidentally the role of the teachers within the paradigm of TaMHS was pivotal because it was through them that suitable children were identified, their names placed on the relevant registers and then referred to TaMHS. The extracts below support this point:

We use the 'Vulnerable Child Register' which we use to highlight children's emotional and social needs. When we see a marked change in their behaviour we then refer them to TaMHS. We can't refer everyone on the register because they don't have the capacity to cope with all the numbers. The ones we felt were most in need of help were the ones we referred...I suppose the ones we referred all had behavioural problems

(SENCo: Sparrow Primary School)

TaMHS has something called the Vulnerable Children's Register

(Head Teacher Hen School)

Comment

There is an assumption from what has been discussed so far that mental health

difficulty equates to some extent to observable and explicit behaviours. In the parent interviews it was clear that the behaviours their children were exhibiting were overt. There is therefore a clear sense that the more heightened the problem or behavioural difficulty, the more likely the child's name would be put on a register and in turn offered a relevant resource to access. In other words there was an understanding amongst the respondents that the less overt a behaviour, the less likely a label would be attached to it. The absence of a label attached to a child's difficulty means the less likely a resource in the form of therapeutic interventions would be offered. What needs to be stressed here is the fact that not all displays of overt (and to some extent) deviant behaviour is an indication of mental health difficulties but more importantly, there are children who do not display any overt or deviant behaviour but still have significant mental health difficulties. Within my schools, it was the children who were displaying more common and overt behaviours in the classroom that were more readily labelled rather than those whose behaviours were hidden. As already mentioned because teachers do not normally have expertise in the identification of mental difficulties in children there is the possibility that a number of children will be denied an appropriate resource with schools because their needs have not been noticed. In the following theme 'comorbidity' the head teacher of Robin School gives an example of a child who tries his best possible not to be noticed or stand out in the class. It will take a very skilled teacher to notice behaviour that is so well hidden.

The issue of identification is an important one but so is the capacity to meet the children's needs. The SENCo from Sparrow School intimated that the demand for TaMHS far outweighed what the resource could provide. Even if teachers become

more skilled in identifying children with deep seated emotional needs there has to be adequate resources to address these needs.

4.6.7 Theme 7: Comorbidity

Three of the children interviewed were identified as having a diagnosis of an Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD).

However, because none of the children had a Statement of Special Educational Needs it could be assumed that the presence of these disorders did not greatly affect their behaviour and therefore their overall access to mainstream education.

The difficulty regarding access to TaMHS therapies is whether the presence of a disorder alters a child's coping strategy when faced with emotionally demanding experiences. Another variable to consider is the child's ability to communicate effectively with the therapist as both ASD and ADHD are sometimes associated with poor social communication skills.

Whatever the difficulties were, it was agreed by both the parents and the teaching staff to refer such children to TaMHS. The extracts below are the views of the head teacher from Robin Primary School:

J he is a year six pupil, came to us not until beginning of year five and he's year six now. He's very quiet. He's ADHD. He's had individual support from TaMHS. He comes from a very disaffected family. His sister has ASD and he is almost withdrawn. So he almost doesn't get noticed because he doesn't do anything that will bring attention to himself down to his work. Gives the opinion that he's quite capable but underneath he's really not. He needs some support in order to make good progress.

L wears Maskers, just to mask out the rest of the world because he has a hearing impairment. And he now has got a diagnosis for ASD and is very anxious and they have a family history of ASD... You're going to speak with L. L has ASD and has sensory issues... He has kidney problems as well as he's got a physical problem as well. He's absolutely desperate not to stick out in a crowd, wants to be totally the same, but he knows he can't have somebody touch even brush by him and that can make him sleep at home.

Comment

It was interesting to note what the head teacher had said about the particular pupils in her school. There was an appreciation that her pupils, in addition to their individual diagnosis, displayed behaviour that had caused their teachers and parents concern. Phrases like 'he has now got a diagnosis for ASD and is very anxious' and 'he is absolutely desperate not to stick out' got me concerned regarding my intention to interview these pupils. Meeting a person for the first time, in my opinion, was bound to cause a modicum of anxiety. Furthermore, asking a pupil who did not want to stand out from the rest of his peers, to meet me for an interview would invariably make him stand out. What the interviews did highlight however was that despite the ASD and ADHD diagnosis (and other sensory, physical and psychological difficulties), the pupils were very willing to be interviewed and through their process of talking to me they were able to articulate clearly the difficulties they faced, the reasons for these difficulties and their attitude and feelings towards therapy. The importance of children having a voice and being able to participate in the affairs that affect them is an avenue of empowerment. This issue of empowerment will be looked at further within the pupils' interviews.

4.6.8 Theme 8: Anxiety

Anxiety is sometimes difficult to quantify because it can be expressed in a number of ways and caused by a myriad of reasons. Anxiety is perhaps best understood as being on a continuum starting from normal behaviour, for example, being nervous about starting a new school, to what is considered abnormal behaviour, for example, the irrational fear of catching germs from people therefore avoiding physical proximity them.

The teaching staff interviewed used anxiety as a label and so this theme overlaps with the previous one. The reason why anxiety is a theme in its own right is because it was specifically mentioned in some of the interviews as seen below:

I think he worries if his brother is going back into hospital and thinks that he may not come home again. It was all the anxiety...

(Head Teacher, Hen School)

You're going to speak to L...He's again very anxious. He has kidney problems as well and he's got a physical problem as well. He's absolutely desperate not to stick out in a crowd...

(Head Teacher, Robin School)

Comment

It would appear from the interviews conducted with the teaching staff that anxiety was an important issue in terms of the emotional well-being of their pupils. Anxiety was seen to be caused by external factors such as domestic violence and marital strife but there was also an internal element that appeared to be causing stress as well. The main internal factor was that some pupils did not want to be seen as

different in relation to the rest of their peers. In other words, they wanted to appear as 'normal' as possible which was causing them added anxiety.

It is not clear whether the anxieties the pupils faced can be deemed as normal behaviour expected within the abnormal circumstances or that their anxieties can be classed as abnormal because their behaviour affected their ability to participate in age-appropriate ways.

What is clear though is that anxiety was recognised as a reason for the pupils to be referred to TaMHS.

The problem that teachers face is that the labels they attach to certain behaviours may not always be embedded within proper psychological and psychiatric frameworks and so there is a potential to 'misdiagnose' certain behaviours that might appear overtly commonsensical to them. This point is therefore also relevant to the role of teachers and labelling.

4.6.9 Theme 9: The Impact of TaMHS

Although the teaching staff were responsible for highlighting the pupils who they thought might benefit from TaMHS therapeutic interventions, (which was based on their own social constructions of mental health), they were not responsible for deciding which therapies the pupils could and should access. The individual pupils themselves were not afforded a choice regarding the therapies they could access either, this was left to the therapists themselves. Unlike specialist teachers or EPs who would often first of all observe a child in class before opting for a particular educational or psychological intervention, the therapists did not do so. The therapists were presented with a register that had the names of the pupils and the difficulties they were having. The therapists then selected certain pupils from the register.

Although there is no evidence to suggest that extensive consultations between the therapists, teaching staff and the pupils took place, overall the response to TaMHS was very positive. Below are a selection of comments which reflect the feelings and views of all the participants interviewed:

It's been brilliant! The way they have been able to help the children has made a noticeable difference in them. The only problem we have with TaMHS as you know is it's short lifespan. We are coming to the end of the three year pilot and we don't know what will be put in its place if anything, when it ends.

(Head Teacher, Hen Primary School)

JD: A marked improvement in her attitude towards school, friends. Seems happier, she has a better way of coping with things and she now has more of a voice. She now has the emotional intelligence to resolve things affecting her. When her mum went back into hospital she managed the situation better.

G is a lot calmer; he now has a settled friendship group; before he had a difficult relationship with his peers. He still has some anxieties but is now contained better. Rather than just running and bouncing off walls, he just fidgets.

(SENCo: Sparrow Primary School)

Comment

The teaching staff I interviewed were very positive about TaMHS; they saw it as an effective and useful resource. Regardless of the therapies accessed by the children, each person informed me that they had observed a noticeable difference in the children during and after TaMHS. The general therapies on offer were art and play therapy, counselling and reflexology which are not readily recommended by NICE.

The therapeutic intervention favoured by NICE however is CBT due to the fact that there is a strong evidence base that supports its use.

Although all the respondents identified TaMHS as being an effective resource I was unable to attain from my interviews whether it was the actual therapies that were effective or the therapists themselves. A third reason could be the effective combination of the therapies and therapist.

4.6.10 Theme 10: The Need for TaMHS to Continue

Closely linked to the impact of TaMHS is the resource's longevity or to be more precise the short term nature of the project. As the three year pathfinder project has now ended there was some clamour for the resource to continue. There is ample evidence from the interviews carried out with the parents, teaching staff and the pupils that TaMHS was well received by all. Due to the reported effectiveness of the use of therapeutic interventions in alleviating the symptoms of emotional stress in the pupils, the teaching staff appeared to be worried about how other children who needed similar interventions would fare after TaMHS had ended. The following excerpts from the relevant interviews stresses this point further:

It would be a great shame if it were not to continue. I still have more than 60 children who would benefit from TaMHS

(SENCo, Sparrow School)

Yes we would definitely use TaMHS if it could continue...The annoying thing is we'd already got the next children that TaMHS would be appropriate for but it is coming to an end

(Head Teacher, Hen School)

Yeah, I suppose, we would continue to use the therapies

(Head Teacher, Robin School)

Comment

It could be argued that TaMHS was effective and well received because it closed a gap which CAMHS could not fill. The children who were perhaps deemed not to be appropriate for CAMHS could access TaMHS as an alternative provision. Unlike CAMHS which is a long which is clinic based and has a very long waiting list, TAMHS proved to be a relatively quick and effective intervention. At the time TaMHS had ended there was not a similar resource to take its place

If the Government's commitment to a programme of improved access to psychological therapies is taken as an intention to address mental health needs as a mainstream issue, then resources like TaMHS should not be a time limited resource. If a resource like TaMHS is to be accessed through schools then there has to be dedicated budgets within local authority education departments to ensure that effective and accessible mental health resources are properly funded.

4.7 Pupil Interviews

Six pupils from three different schools were interviewed for the purpose of this research. Interviewing children presents a different dynamic than when interviewing adults. The interviewer needs to be aware that children are generally more vulnerable than adults and so the questions asked need to be differentiated to the point where they feel comfortable and able to address them. The interviewer also needs to take heed of the language used. Opaque language will not facilitate the right responses and so once again the interviewer needs to be aware of the complexity of language used and to be reflexive enough within the interview process

so that the language used is modified to ensure that the questions asked are understood by them. With four of the children interviewed a long preamble was undertaken before the relevant questions were asked. This was done to relax them and to get them talking rather than asking the pertinent questions straight away which may have resulted in single word answers or no answers at all.

An analysis of the interviews resulted in four congruent themes being generated. The congruent themes are as follows: Family Situation, Attitude towards School, Type of Therapy and, Effect of Therapy.

4.7.1 Theme 1: Family Situation

This is the most common theme as it not only appears in the interviews of the pupils interviewed; it is also a theme that occurs in both the teaching staff and parent interviews. The interviews suggest that the problems that the pupils faced emanated from the home causing them enough distress to warrant a referral to TaMHS. Four of the six children had experienced family breakups which in some cases included domestic violence, complicated and bitter divorce and also fleeing from the family home. In other words, the children's emotional well-being was adversely affected within the family home and was being affected which, in turn, brought them to the attention of the teaching staff. The sixth child (Pupil B), although from a 'stable' family, had become very anxious and depressed about his older brother's well-being. His brother was being treated for leukemia at the time and feared that his brother might die. The difficulties that the pupils faced are summed up in the following interview extracts:

I think my problems started when me and my mum and my sister had to run away from home because of our dad... Yeah, before I was worried that dad will come back and so we would have to run away again

(Pupil G, Sparrow School)

I like the fact that I've got my own room because my brother has been having cancer treatment, so he's had to be waking up at 2.00am, and when he was in my room when we were sharing, it was waking me up too...I didn't concentrate on my work much because I was tired

(Pupil R, Hen School)

My mum and dad are divorced. My dad lives somewhere in Dover or maybe he's moved

(Pupil J, Robin School)

Comment

The importance of the home cannot be over-emphasised. The home is the child's primary base for socialisation and the place where primary attachments are formed. From the interviews there is some evidence suggesting a link between what happens at home and the particular behaviours that are noticed in school. Also the problems that the pupils presented were such that an outside agency such as TaMHS was required.

What was also clear in the interviews were the pupils own understanding of the difficulties that they had experienced; they old had a perspective of what had happened to them. Giving them a chance to air their views underlined a certain level of understanding in which they had regarding their own particular situations at home.

Pupil G was able to give to pinpoint when the problems at home started and Pupil R was able to explain how the illness of his brother affected his normal routine.

What also came out clearly from the interviews were the different family situations which had caused the pupils to feel unhappy and to a certain degree unsafe at home. Domestic situation ranging from divorce to feeling home proved to be unsettling for the pupils but so did the illness of a close family member. The importance of the statements made by the pupils is to highlight that the situation that affects children within the family are caused by a number of factors. This being the case, the adults who work with them need to be aware of this and competent enough in addressing their individual needs.

4.7.2 Theme 2: Attitude towards School

As hitherto mentioned, the school is the place children spend the most time after the family home. The link between the home and the school as it has already been highlighted in the interviews with the parents and the teaching staff and so it is not surprising that the issues affecting the children in the home were being picked up in their respective teachers in school. The link between the home and the school is therefore a tangible. Despite their experiences at home impacting on their behaviour and presentation in school, the pupils interviewed all had something positive to say about their time spent in school:

I enjoy literacy because I like to write stories and do stuff about imaginary settings...I like to play. You can see out the window all the space in the field

(Pupil B, Robin School)

I like Maths because it is fun adding things together. And I also like Art and DT because you're making things, and it's usually fun

(Pupil R, Hen School)

I like some of the teachers and I like some of my friends

(Pupil JD, Sparrow School)

I didn't like this school when I first came here. I missed my old school and started to get into fights. I didn't have friends and I hated being here...

...later said that:

I think I'm better now; I don't get into so much trouble anymore

(Pupil G, Sparrow School).

Comment

The fact that each pupil had something positive to say about their schools reflects to some extent the input of the teachers and the overall ethos of the schools in general. In my interviews with the teachers I mentioned that the schools that were chosen to be part of TaMHS were primarily based on location; that is those based within the Peninsula and the North of the local authority. There were other factors that also taken into consideration, for example, the level of pastoral support already available within these schools which included the social and emotional aspects of learning and also the links the schools had with the community. Although the interviews with the teacher staff revealed that they did not always feel competent enough in dealing with the emotional difficulties that their various pupils presented with, the pupil interviews did show pupils that the school/classroom was a happy place for them. Even Pupil

G, who admitted that he found school difficult at first later on found it to be a less challenging place.

Three of the children focused on the academic element of schooling and were positive about it. It could be that having lessons that they enjoy and which in addition gives them a sense of achievement allows them to view their schools in a positive light.

4.7.3 Theme 3: Type of Therapy

The list below shows the therapies the pupils were able to access:

Pupil B (Robin School): Art Therapy

Pupil J (Robin School): Reflexology

Pupil L (Robin School): Reflexology

Pupil JD (Sparrow School): Play Therapy

Pupil G (Sparrow) Play Therapy

Pupil R (Hen School): Play Therapy and Reflexology

None of the pupils made direct reference to TaMHS in the interviews but they were all able to name and describe the therapies they were able to access. It would appear that reflexology and play therapy were the interventions that were the most readily available. Pupil R was the only child who was able to access more than one type of therapy. The interview extracts below highlight their description of the therapies:

Ah yes! I talked to someone, she was not a teacher, I can't remember her name but we did a play thing together

(Pupil JD, Sparrow School)

Oh yeah, I remember; it was a lady called 'H'. We used to do play therapy together. I used to like having play therapy

(Pupil G, Sparrow School)

I was doing foot massages

(Pupil L, Robin School)

Comment

As already mentioned in the teaching staff interviews there were a number of therapies on offer but the way in which the pupils were matched up to them was based on whether their names were on a particular register or not. Whether a true consultative process took place whereby the parents, teachers and especially the pupils were involved was not made clear during the interviews. As the therapists were not involved in my research I was not able to ascertain whether the types of therapies offered were specific to the particular mental health difficulties the pupils had or if they were only offered the therapies that were available at the time.

As mentioned previously in the teaching staff interviews, the demand for therapies through TaMHS was such that not all the children who needed it were offered it. Having a register was possibly a way at controlling the number of children who needed to access the resource.

What is clear from the interview extracts is that fact that the pupils were aware of what therapies they had accessed and this is evidenced by their descriptions of them. What is also revealing is that they all felt part of the process. Therapy was not something being done to them but a resource in which they were able to engage with. Therapy was something that involved them and the therapist. As these therapies are largely non-directive it could be assumed that the pupils had some degree of control regarding its intensity and direction.

4.7.4 Theme 4: Effects of Therapy

Although the pupils had no choice over the therapeutic interventions available to them, their overall response to TaMHS reveals that they found it to be a very positive experience. The pupils were able to evaluate the effectiveness of the therapeutic interventions they accessed in their own words.

I was having reflexology on my feet. They were touching certain parts where the nerves were in your feet. Then they put different flavored cream on your feet and then they did it. Once they had finished they put some more cream on. Because when they were doing it the cream got rubbed into your foot. So once they had done it, they put more on, so it would stay on there. After that I felt really calm and relaxed

(Pupil B, Robin School)

I liked going for play therapy because I was able to tell her things that I couldn't tell my mum. It gave me space to think...We used to play with stuff. I wasn't told what to do like in class but when I was making things I was able to tell H about things that was bothering me

(Pupil G, Sparrow School)

Comment

By being able to relay their own experiences of the therapies that had accessed gave them a degree of legitimacy and power. It also validated the effectiveness of the therapies accessed regardless of the evidence base evaluating them. Allowing the pupils that time and space to air their views, it could be argued, is empowering for them. The power dynamic between the pupil and researcher changed slightly because through their participation and therefore agency, they were able to give me the information I needed. I was more reliant on them for the information and they had the choice regarding how much they wanted to reveal to me. Children's agency serves as building blocks of their identity because through participation choices are made and in turn these choices reflect their preference for one thing over the other. When children have the opportunity to make preferred choices it acts as an insight into their identities.

It needs to be stressed again, even though it has been mentioned in various sections of this thesis, that at no point did I ask the pupils to reveal the minutia of exactly what took place between them and the therapist during their therapy sessions. I was aware of the therapist/client confidentiality clause and so made sure that my interview questions did not breach it.

4.8 Conclusion

This thesis has argued that mental health difficulties in children and the way it should be addressed is best understood within the social ecological paradigm. As mentioned in the first chapter, children are inextricably linked with their families, friendship/peer groups, their schools and the wider community (Bronfenbrenner, 1979). It is the premise on which the Framework of Assessment (DoH, 2000) is

based; it is an effective tool which highlights the importance of support networks within a social ecological paradigm. Within this paradigm is the notion that the family is the child's immediate source of support for children but as the interviews have shown, the family can also be the unit responsible for the stress caused to children and invariably their mental health difficulties. A theme common to all the participant groups was the 'Family Situation'. In each of the interview groups the respondents were able to state clearly the effects of family strife or upset had resulted in the children needing to access TaMHS which is common in all the three participant interviews.

When the family was no longer able to provide effective and sustained support to their children within the respective schools were seen as a valuable resource. The support the schools were able to provide to both children and their families underlines the importance of the social ecological perspective within the context of mental health. The themes 'the location of the school', 'the role of school' and 'socio-economic factors highlight the school not just not just a social and emotional resource for children and their families but also as a physical edifice which is at the heart of certain communities.

The findings in this chapter also relate to three of the four research questions posed in the first chapter of this thesis:

How is mental health understood and constructed? This question was answered specifically by the following themes: 'Family Situation', 'Parents' Appreciation of Difficulties', 'Mental Health Constructions' and 'Labelling'. The adult participants were able to explain in their own words the particular behaviours they had seen and in doing so constructed their own understanding of mental health. As the epistemological position this thesis adopts is social constructionist one the author is

of the opinion that the views and constructions of the participants in relation to mental health are valid. Closely related to this thesis's epistemological position is the ontological stance adopted which is a relativist approach. This position presents as an antithesis to the positivist approach by accepting that there are a myriad of truths rather than there being just one explanation or truth. If we are to understand fully the machinations governing our social world then we have to accept different interpretations. That is why the perspectives of the participants have to be accepted.

To what extent are children able to participate and have their voices heard?

The interviews gave the pupils involved the opportunity to air their views regarding their family situation, feelings about school and their experience of therapeutic intervention. The discussion chapter will delve into more detail regarding this research question.

How are therapeutic interventions evaluated by children? TaMHS specific publications such as 'Me and My School' (DfE, 2011a) contains an overall evaluation of TaMHS but not by the recipients of the therapeutic interventions – the children. The pupils' view of TaMHS, the description of the therapies and the way in which they engaged with them was an attempt to redress the actuality that in the wider evaluation of the resource they were not consulted. The evaluation of TaMHS from the perspective of the pupils themselves if there is a mechanism whereby their views can be effectively be fed back to the system. Although TaMHS has ended in a number of local authorities there views about therapeutic interventions and the process by which they were able to access should still prove to be of some value.

Chapter 5

5 The Discussion

5.1 Introduction

In this chapter the salient points that emanate and emerge from the findings are discussed in relation to the relevant literature and theory underpinning this body of work. This chapter is divided into four sections: (1) the findings that emerged from the thematic analysis highlighted in the previous chapter (2) the obstacles encountered within the process of conducting this research and its significance to the role of the EP (3) the limitations of the research (4) the implications for further research.

5.2 Main Findings

The previous chapter highlighted 18 themes that were extrapolated from the interviews undertaken with the three participant groups. Some of the themes covered similar grounds and hence overlapped with each other. They could have been collapsed into single themes but because of their subtle differences I decided to categorise them individually and is so doing discuss them as entities in their own right. The research findings relate to the first three research questions which cover three main areas: (1) constructions of mental health (2) children's participation within mental health paradigms (3) how children evaluate therapeutic interventions (4) the role of the EP in mental health

The fourth question which considers the role of the EP was not directly addressed in the research findings but is added because the overall research has implication for the role of the EP within mental health.

5.2.1 Constructions of Mental Health

In the first chapter of this thesis some relevant constructions of mental health were highlighted and discussed. The point made was that within mental health paradigms the views, perspectives and appropriations of relevant professionals are accorded more power and value than the constructions of lay people (Waterhouse and McGhee, 2002, Boyle, 2007, Spender et al, 2001). Foucault (1980) highlights the power dimension between professionals and patients within mental health paradigms and likens it to a form of oppression because the patients who are deemed to be mentally ill and in receipt of mental health interventions have minimal agency in relation to doctors/psychiatrists.

The TaMHS research undertaken does not conform to Foucault's (1980) stark dichotomy between the professional and patient, firstly, because TaMHS, when it was in operation, was not based within health settings and therefore not influenced by the expertise of the psychiatrist, and secondly, the therapeutic interventions were not strictly imposed on the children unlike adults who can be 'sectioned' on the advice of relevant professionals. What the findings do highlight, however, is the importance placed on understanding the difficulties the children were experiencing. Before the pupils were referred to TaMHS, their experiences and backgrounds had to be 'constructed' in ways which made them eligible to access the resource. Family circumstances, socio-economic factors and personal difficulties all helped in constructing the children as being vulnerable and therefore in need of appropriate interventions:

I was more concerned about my son getting the help he needs...In terms of his problems I think that it was the family break up that caused his problems but I

wouldn't say he had mental problems, it was more family emotional problems if you get what I mean. I would have accepted any help at the time because I was having problems of me own

(Parent of J)

As you may well know we are the poorest area in...and with it comes its own peculiar issues. Many of our children live in homes that are on or just above the poverty line

(SENCo, Sparrow School)

Many of our parents are unemployed and we have a very high incidence of one parent families. I use the term one parent families very loosely because a more accurate term is single mum families

(SENCo, Sparrow School)

With our families we've had bereavements, very close bereavements, we have parents who have died, two mothers have died of very young children at the school. We've had split marriages, adoption, looked after children. And the problems associated with that, for example, neglect and some disclosures of abuse from peoples. And I think that's probably about all, if not more.

(Head Teacher, Robin School).

The findings highlight the importance of constructions, especially when appropriated by relevant adults. In order for pupils to access the therapies offered through TaMHS, they needed to fit the ideal type, that is, the construction of a child with significant enough social and emotional difficulties. There was an inherent understanding among the adult respondents that if no label was attached to a child's

difficulties then it would have been unlikely that a resource such as TaMHS would have been made available. A label according to Jary and Jary (1991) is a socially attributed term in which individuals or groups of people are ascribed categories which confirm particular behaviours and influences identity. A label appropriated in this way carries with it the assumption that something or someone needs to be 'fixed'. This view is supported by Ogilvy (1994) who notes:

While labels may be indicative of educational problems, it does not necessarily follow that they suggest relevant solutions; that is, the labels themselves do not always provide specific details regarding what you do about it

(Ogilvy, 1994, p.6)

The argument I put forward here is that even though labels may not necessarily change the essence of who a child is, it does bring about a change in the way the child is related to because the label becomes part of that child's identity. As highlighted in the first chapter of this thesis, formal constructions underscore the power differential between children and professionals because the process in which a label or, in medical terms, a diagnosis is given, positions children within a situation in which they become passive recipients in the formation of their own identities. In other words, the constructions adults have of children, in turn, become part of their identity because they have the power to define who children are and what they need.

The process whereby some children are given labels denoting mental ill health could be construed as an admission that without them, and subsequently without the intervention, the child would face more difficulties and would be further socially excluded in class and within the school as a whole. In other words, rather than labels being tools that identify social exclusion, they could in fact help in highlighting the

difficulties such children face and therefore become a conduit through which they can access the help needed. Rothi et al (2008) argues that for professionals and parents, a diagnosis or a label represents the first steps towards helping them access a resource or some form of support:

The 'diagnosis' provides an explanation for their children's behaviour, helps them to understand and cope with their special and distinctive difficulties, and facilitates access to special education and therapeutic facilities

(Rothi et al,2008, p.248)

The authors however; urge caution regarding the use of labels as a means of accessing resources. They point out that even though labels are important in accessing resources they also have the tendency to place people in categories which have the potential to deny them their individuality. Crow (2003) in the same vein argues that labelling feeds into the idea of normalisation; the process she says creates the illusion that the best way to understand people's difficulties is to deny or de-emphasise their difference which she asserts is common within mental health paradigms. Burke and Parker (2007) also advise that an element of caution be taken when focusing on the importance of labels. They stress the fact that labels as a whole are superficial because they only identify a diagnosis of difficulty or difference; they do not thereafter change who the child is. Within TaMHS however; labels were used in positive and effective ways because it resulted in children being able to access therapeutic interventions.

What can be deduced so far is that there is a cogent link between social constructions and labelling and that in tandem they potentially lead to resources being addressed. The research findings suggest that within TaMHS, social constructions in relation to mental health resulted in the appropriation of labels

which, in turn, allowed children access the help that they needed. It needs to be made clear that social constructions and labels in themselves do not lead the provision of appropriate resources. Wright et al (2001) point out that labels are only lay descriptions and in themselves do not confirm a diagnosis. Within health paradigms a lay person cannot normally request specific medication without a diagnosis first being made. The patient may describe the symptoms being experienced, which may be useful in the actual diagnosis, but the lay description does not confirm a diagnosis. What the authors do stress in their study is the usefulness of such descriptions which they say may lead to their needs being addressed. In their study the children and young people who were able to describe their mental health symptoms with a relative degree of accuracy were six times more likely to be given a correct diagnosis and hence an effective intervention.

The participants in Wright et al's (2011) study were young people aged between 12 and 25 and therefore significantly older than the children in my research. Furthermore, the dynamics were quite different. The authors state that the participants in their study presented their symptoms to the doctor's directly suggesting that they had greater agency within the doctor/patient relationship. The dynamics within TaMHS was very different because the children accessed the therapies not directly but through their respective schools. Their difficulties had to be socially constructed and labelled by their parents and teachers before therapies could be offered to them. This highlights the extent to which children are able to participate and have their voices heard. This point will be addressed in the relevant section of this chapter.

Taylor et al (2010) adopt a slightly different approach, they focus more on how social constructions of mental health can affect the self esteem of children due to the

influence of the medical model which according to them promotes a deficit understanding of mental health at the expense of understanding it through a social ecological perspective. In their opinion, although labels that are derived from such constructions can be either positive or negative its main aim is to ensure that children are able to access the provisions needed. The authors make reference to the SEN Code of Practice (DfEE, 2001) and argue that some aspects of it adheres to the within-child (deficit) model because the appropriate educational resources and support can only be provided if a child has a negative label which meets the set criteria. The interview extract below there is evidence of how such a label or construct is used to place children on a particular register which in turn became the medium through which certain children were able to access the TaMHS resource

We use the 'Vulnerable Child Register' which we use to highlight children's emotional and social needs..The ones we felt were most in need were the ones we referred...I suppose the ones we referred all had behavioural problems

(SENCo, Sparrow School).

It is unclear whether it was the negative labels the pupil accrued before therapy, the therapy, or the pupil himself who brought about the change in his behaviour. What is clear however, is that the mere fact he was referred to TaMHS means that there was a greater understanding of his behaviour by the relevant adults around him, which then led to his needs being addressed.

5.2.2 The Process of Mental Health

I used the term process to suggest that when a person is identified as having a discernible mental health problem it is expected that the said problem will be addressed. The purpose of addressing such need is to return the person back to

some state of good health; this was the main aim of TaMHS (DoH, 2011). The time from which a problem has been identified up until the point it has been addressed represents a process. According to Goffman (1967), a specific 'career' path or process is embarked on the receipt of a label highlighting a mental health difficulty. Without a label it is likely that the pupil's career path continues on an unaltered trajectory through school. In this scenario a label is significant if change is to happen; it is a catalyst for something happening later on in the process.

A strong theme that emerged through the research finding in relation to labelling is the idea that children offered interventions through TaMHS were also on a specific 'career' path, that is, there was a realisation from all the respondents that the pupils' behaviour or emotional difficulties were the main catalysts in getting them referred to TaMHS; the extract below highlights this point:

Emotional health, self esteem and even mental health all mean the same thing; it means that something is going on in your head and in your heart and so help is needed

(Parent of G)

(Goffman, 1967) gives an account of the 'career' of the mental health patient is given. In this context, career does not refer to the progression certain professionals experience within the world of work, but a lifestyle which places a person beyond the norm:

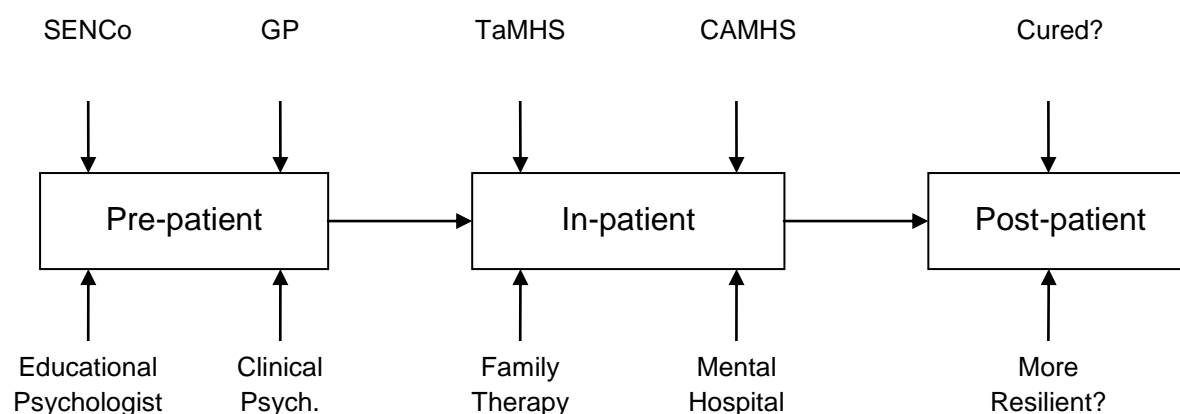
The psychiatric view of a person becomes significant only so far as this view alters his social fate, an altercation which seems to become fundamental in our society when and only when, the person is put through the process of hospitalisation

(Goffman, 1967, p.120)

Goffman (1967) adds that for this reason the negative label of mental illness only applies to those who have been assessed and then admitted into a hospital. He adds further that there are a number of people with mental health problems who have avoided hospitalisation and because of this, have not been labelled as having mental health problems. It could be argued that the use of the Vulnerable Children's Register and the Child Protection Register for TaMHS, relates to what Taylor et al (2010) refer as the function of negative labelling. Not all children with mental health difficulties were able to access TaMHS and therefore not put on the same 'career' path of those who did.

Goffman's (1967) idea of the career of a mental health patient is explained in three stages: the pre-patient stage; the in-patient stage' and the post-patient stage. In adapting Goffman's theory to this research, the pre-patient phase relates to the point a pupil's behaviour or emotional presentation becomes of concern and so subsequently receives an appropriate label. In clinical terms this may relate to the point at which a person feels unwell and visits the GP. The in-patient phase occurs when the pupil is referred to, and is therefore in receipt of TaMHS therapeutic interventions. In parallel, this phase can relate to the point at which the patient is given medication. The post-patient phase refers to the time the therapeutic interventions have ended and hence the pupil is 'discharged'. The point of discharge, I argue later on in this chapter is where EPs can fashion a role for themselves. The diagram below (Figure 5.1) illustrates a career path a typical pupil referred to TaMHS may have gone through.

Table 5.1 The Process of Mental Health 9



5.2.3 The Pre-Patient Phase

Common to all the schools taking part in the TaMHS project is the process by which the pupils at the various schools were offered therapeutic interventions. This phase is reliant on the construction and identification of a mental health problem. It is arguably the most important of all the three phases because it is at this stage the 'career' starts. As discussed in the previous chapter it was highlighted that teachers may not be adept at recognising less obvious signs of mental ill health, for example, pupils who do not want to be identified and so adapt their behaviour according as the example below makes clear:

You're going to speak to L...He's again very anxious. He has kidney problems as well and he's got a physical problem as well. He's absolutely desperate not to stick out in a crowd...

(Head Teacher, Robin School)

There are differences of opinions that exist regarding the expertise and aptitude of teachers within the paradigm of mental health. Humphrey et al (2010), for example,

are of the opinion that school staff are rarely utilised, other than when they are asked to rate children's behaviour and well-being. According to them, this does not often involve empirical precision but on overtly observed behaviour. The most obvious children are the ones who get noticed. When asked if TaMHS was a beneficial resource, the SENCo from Sparrow School replied thus:

Definitely! I've got a list it would be a great shame if it were not to continue. I still have more than 60 children who would benefit from TaMHS

The possibility exists that there were far than the SENCo actually realised

5.2.4 The In-Patient Phase

Goffman (1967) observed that patients with mental health problems thought that the sooner they were treated, the sooner they could return to the 'normal' existence of mainstream society. The main purpose of TaMHS was to alleviate the symptoms causing pupils emotional distress and in doing so, change their behaviour and outlook for the better in order to aid his or her full integration back into the classroom (DCFS, 2008). This, however; may be construed as a process of normalisation which Crow (2003) stresses, denies those within it a sense and semblance of individuality. Within the classroom, however, for a child to learn effectively, a modicum of what is considered normal behaviour is expected and so an intervention which brings about some normality in a child's behaviour is welcome by the class teachers, as the extract below shows :

..he has learned how to deal with the dynamics within the within the classroom a little bit more...TaMHS led up to that and I think that's made a huge difference at home

(Head Teacher, Robin School)

The in-patient phase signifies the fact that the patient will be treated according to the symptoms presented with. The way in which TaMHS was set up meant that the children who accessed it did not have to go into a hospital or clinic for 'treatment', nevertheless they were offered therapies aimed at alleviating the symptoms they presented with. Dawson and Sing-Dhesi (2010) in their research on the CBII in Leicestershire remarked that it was a resource that offered quick and effective interventions for the children and families who were in need of it. The authors stated further that SFBT was the therapy of choice within CBII; their evaluation of the resource including the therapy offered resulted in more than 60% of the service users reporting that the interventions offered were effective. The in-patient phase represents a transient point between ill health and good health.

5.2.5 The Post-Patient Phase

This phase represents the end of the therapeutic interventions pupils have received. Under the medical model an intervention is evaluated on the basis of how effective a pharmacological or surgical intervention has been. It is a quantifiable process which is judged on the level of cure a patient experiences. Feedback from the respondents indicates that TaMHS interventions were received and evaluated favourably but the long term effects of the therapies was not that certain. Pupil J (Robin School) when asked about his views regarding reflexology responded by saying:

It made me feel happy and relaxed

When he was asked if he still felt relaxed he said:

Not really

Another when asked about the effects of therapy said:

Usually I got a free foot massage, nice creams that smells really relaxing... Yeah it improved me... Although I think that I am a lot calmer, I still lash back; that will never improve

(Pupil L, Robin School)

Although the research findings confirm that both the pupils and the teaching staff were generally positive about the therapeutic interventions, it needs to be emphasised that the long term effects of these interventions were not evaluated within this research. A longitudinal study would have been able to highlight the long term effects of the therapies by interviewing the same respondents over a period of time. The way in which the children felt during and post-therapy and the positive changes in behaviour observed by the teachers is evidence that in the short term at least the therapies were successful:

It's been brilliant! The way they have been able to help children has made a noticeable difference in them

(SENCo, Sparrow School)

I certainly think it's been a wonderful thing, I mean the difference in some of the children

(Head Teacher, Hen School)

I think J is able to voice his responses about himself, to join in a bit more, to feel more confident

(Head Teacher, Robin School)

The post-patient phase can therefore be evaluated in terms of dialectic. According to Outhwaite and Bottomore (1994) dialectic is:

In its most general sense, dialectic has come to signify any more or less intricate process of conceptual or social conflict, interconnection and change, in which the generation, interpenetration and clash of oppositions, leading to their transcendence in a fuller or more adequate mode of thought or form of life, plays a key role

(Outhwaite and Bottomore, 1994, p. 154)

Dialectic means a process of change whereby the end product is significantly different from the starting point. TaMHS was aimed at bring about a positive change in the lives of pupils who had experienced significant social and emotional difficulties. The difference between the pre-patient phase and post-patient phase relates to the changes seen in pupils' behaviour and emotional well-being from the time their names were placed on the Vulnerable Children Register up until the point they received TaMHS therapeutic interventions; as the diagram below illustrates.

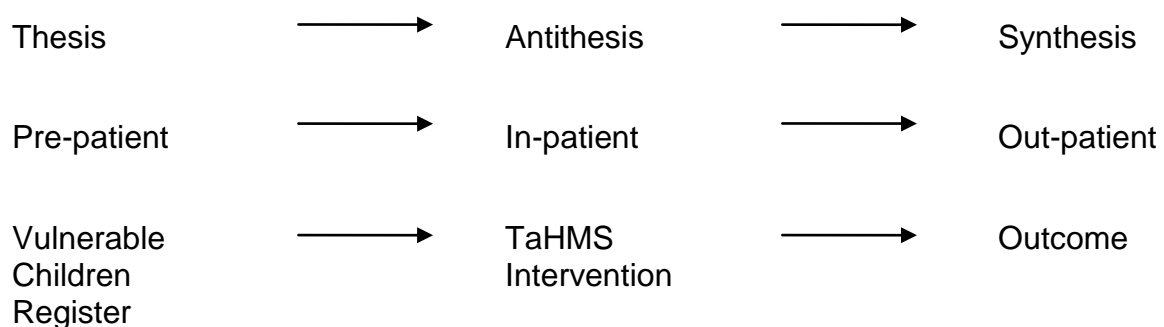


Figure 5.1 The Mental Health Dialectic 5

5.3 Children's Participation within Mental Health Paradigms

The main aim of interviewing children in this research was to understand the constructions of mental illness from their perspective or, conversely, the antecedents regarding their behaviour. A common theme that emerged from the interviews was the realisation that the children's behaviour and emotional well-being could not be divorced from the wider socio-economic context within which they live, especially the family situation as the extract below:

These mums have partners or ex-partners who do very little in the raising of their children... We have families fleeing from domestic violence and some where domestic violence is apparent

(SENCo, Sparrow School)

I think a lot of it is to do with the rural deprivation. I think, especially where you've got one- parent families, they're on handouts, so there's not a lot of money. So, everything is very tight

(Head Teacher, Hen School)

As some of these children were not realising their true emotional and social potential; it can be deduced that their mental state to a certain extent impinged directly on their academic performance in the classroom. Incidences within the family such as death, domestic violence and divorce became subsumed within their behaviour and hence their emotional state. Regan (2009) too makes the link between mental health and academic performance:

Separating the emotional from learning is like trying to conjure a water molecule without oxygen as a component. In short, if we want to teach facts

effectively, we need to work with the emotional, we cannot have one without the other

(Regan 2009, p.10)

The issue was not whether children were being given a voice; it was more to do with their agency within the household. It could be argued that even though incidences involving parental strife sometimes happen in the presence of the children the true impact on their emotional well-being and identity was not always taken into consideration. In their paper on divorce and its impact on children, Taylor et al (2011) remarked that children who experience marital strife leading to divorce are much more likely than other children to internalise the anguish they are feeling regarding the situation. Taylor et al (2011) deliberate further by adding that the internalising of children's feelings and thoughts in such situations eventually result in mental health problems which sometimes continues through into adulthood. The internalising of thoughts and feeling is a path well trodden when people do not feel safe enough to voice such thoughts and feelings. In effect, it is the children's lack of agency within a particular situation that in turn may result in mental ill health. Mowat (2010) emphasises the point about children's agency and argues that not only is it a legal right, it is also an imperative if children's well-being is to be promoted and maintained within both the home and the classroom:

Without being able to exercise agency, these goals cannot be achieved. Whatever the explanation provided for pupils' behaviour, it is not helpful for children to be cast in the role of an inanimate object with no control over their lives, whilst recognising that, for some, the barriers to exercising agency may be great.

(Mowat 2010, p.191)

In relating the issue of children's agency within education, Costley (2000), uses the analogy of consumers' right to make the point about children being listened to:

We would not think of constructing a case study without collecting the opinions of the adults involved in a situation, so why would we ignore the views of the consumers of education – the children?

(Costley 2000, p.172)

Allowing children a voice goes beyond affording them a say in the matters that affect them; it is about giving their deliberations currency by acting on whatever they say with thoughtful consideration. Within TaMHS this aspect of children's agency has proved difficult because, as alluded to in the previous section, whatever was discussed during their therapy sessions remained within the confines of their therapy. Teachers and parents were not given feedback regarding how to promote and maintain the emotional well-being of these children. In other words, there was no feedback loop to inform the actions of the relevant adults involved. This is not a criticism of TaMHS or the therapeutic interventions they offered, it is more of a critique of special needs education and how therapies are utilised within it. At the moment, because the voices of the children who enter into therapy are not heard, other relevant resources such as EP interventions are not able to build on what has gone on beforehand in order to help such children further.

It should however be stressed that listening to the voice of the child or promoting the agency of a child within professional and therapeutic paradigms is not a straight forward task. This is because the adult working with the child could be an impediment to the child's agency. Day (2008) points to the fact that children may react to an adult interviewing them with a mixture of defensiveness, reluctance, resentment and fear. The author adds that within such situations children may find

the questions they are asked intense and difficult, thereby making it hard for them to express their feelings and attitudes. Day (2008) and Hall (2010) offer a critique of children's participation and are markedly aware that structures need to be put in place if their voices are to be properly heard. Day (2008), for example, highlights the importance of legislation such as the Children Act 1989 and says that it gives children the legal right to have their voices heard, not only within schools but mental health resources such as CAMHS. Mizrahi, et al (2009) however; state that people in general are often afforded less say within mental health structures because they are deemed as having very little understanding of mental illnesses.

Day's (2008) point about the in which some children become impeded within interview situations was realised in my interview with JD (Sparrow School). At times she found it difficult to respond fully to the questions put to her. During the session I asked her if she wanted to leave the room (thereby terminating the session) but she insisted on staying. It soon became clear during the interview that she found some of the questions difficult to understand. This was her response to the question: What were the problems you had at home?

When we first got DJ (a cat) he kept going under the washing machine so we had to move the washing machine...Also my sister lied to be that she didn't chuck my book on the floor

Afterwards I had to change the way in which I asked the questions. The questions had to be differentiated to the point that she was able to respond appropriately. Therefore, when I asked a question about her father, she responded thus:

Dad lives in G, I don't know why he doesn't live with me. I miss my dad because I only see him two times a week

In spite of the difficulties JD had in responding to some of the interview questions, Amato and Tree (1987) encourage those working with children within the context of interviews to persevere because it is a setting where valuable information in terms of family data can be collected. As JD, struggled with some of the interview questions I terminated the interview early and thanked her for her participation. Although the interview was not completed, she was still able to furnish me with some information regarding her background thereby confirming the importance of interviews as stressed by the authors. The value of this interview undertaken with JD and the extent to which it promoted her agency needs to be addressed.

Although JD was able to furnish me with some information regarding her family I did not get a true sense of agency within the whole interview process. JD did not really have the language or understanding to express herself effectively especially in relation to the therapy she received and her feelings about it. In the literature review I highlight the point that both Day (2008) and Hall (2010) reject the model of participation offered by Hart (1997). Their argument is based on the idea that within the aforementioned model, children will find it difficult to pass the tokenistic stage in reference to their participation within adult oriented structures. Although JD had the opportunity to participate in the interview, the actual extent in which she was able to do so effectively is not that clear. This issue will be highlighted later on in this chapter where the limitations of this research are discussed.

What this research does highlight though is given the opportunity children are to differing levels able articulate their feelings and in doing so shed light on the issues that affect them. The purpose of me interviewing children was to understand their views and reasons for therapy; however what the interviews have highlighted are the very important environmental and family issues that have impinged upon their

behaviour and also their academic and emotional well-being at school. This it could be argued is a relative strength of this research. Aston and Lambert (2010) in their research arrived at the following conclusion:

Many young people questioned in the present study ultimately felt that their voices are currently only occasionally or 'partially' heard. They were, however, to identify ways in which situations could be improved. Given that much recent legislation suggests the situation has to improve, it would seem foolish to dismiss the apparently considered and potentially useful views of the young people themselves

(Aston and Lambert, 2010, p.50)

5.4 The Role of the EP in Mental Health and Therapy

The extent of the role of the EP in delivering therapy or therapeutic interventions is a pertinent point for discussion. The word 'therapy' is a term borrowed from medicine and means the different methods of treatment and healing, and in particular the use of medicine or drugs in addressing illness and disease. Therapy has now adopted a more holistic meaning and is frequently used in applied psychology and alternative medicine. The delivery of TaMHS in schools was therapy based and, as mentioned elsewhere in this thesis, in some local authorities the delivery of the therapeutic interventions was EP-led. Leadbetter (2010) draws our attention to the fact that even though a number of EPs think they are not therapists, they do believe that a proportion of their time should be given to working with children who are experiencing emotional and mental health needs. In effect, working within mental health paradigms ostensibly means delivering therapeutic interventions or at least supporting therapeutic intervention.

One of the criticisms that the TaMHS therapists levelled against EPs was the idea that we are not suitably qualified to deliver therapy and hence not suitable qualified to evaluate such interventions. This assertion runs in parallel with the debate regarding CBT and whether EPs have an extensive enough training in order to deliver it effectively. Squires (2010), explains that CBT is a therapy used with adults as a means of alleviating mental health disorders. Squires adds that the CBT model has been adapted to the needs of children and young people especially in relation to their communicative needs. CBT is often delivered by CAMHS workers, therapists or counsellors in clinics and hospitals. Squires (2010, p.297) emphasises the point that:

This approach is likely to be a therapeutic approach to 'treat' mental 'disorders' and make diagnoses'. It has a language that is slightly alien and causes some unease to educational practitioners, who are more likely to construct emotional and behavioural difficulties in terms of the social environment, social perceptions and social interactions

It would appear that the sudden clamour for EPs to deliver CBT is because it is one of the very few non-medical interventions recommended by NICE and has an evidence base for its effectiveness. Squires argues that EPs are suitably trained to deliver CBT with children in schools. EP training even at doctoral level cannot match the time it takes to fully qualify as a CBT specialist which is, at least 450 hours of training and over 200 hours of supervision. EP training even at doctoral level cannot match that. The research undertaken of an early intervention resource by Dawson and Singh-Dhesi (2010) highlighted the effectiveness of SFBT which was carried out by an Assistant EP. Rather than focusing on one particular therapeutic intervention, EPs need to have an extensive repertoire of therapeutic skills in which they have a degree of confidence and expertise in using.

The argument that Squires (2010) puts forward in favour of EPs delivering CBT is that in relation to therapists, EPs have a much broader training and are specifically skilled in working with and supporting children in schools rather than in clinics. Adapting CBT into Cognitive Behavioural Psychology, that is, using elements of CBT and adapting the way it is used in order to make it relevant to EP-focused approaches, is a worthwhile step to take.

My argument differs slightly from Squires (2010) in that I question whether we need to focus on CBT as much as we do now. Primarily, CBT is based on the medical model; it is directive and therefore places the practitioner in an overly powerful condition in relation to the client. EPs work in more collaborative ways through consultation and negotiation rather than direction (Mizrahi et al, 2009, Day, 2008, Hall, 2010).

EPs who work directly and therapeutically with children have always used one form of therapy or the other be it utilising solution-focused interventions within a problem solving paradigm, counselling techniques, personal construct psychology or any other psychology intervention. EPs are not restricted to any one particular model, and EPs unlike general therapists and CBT professionals, are trained exclusively in working with children, young people and their families in different contexts. EPs are not restricted to clinics or therapy rooms but are encouraged to work systemically flexibly and innovatively with children and their families which is in line with a social ecological overview undertaken within this thesis

5.5 Obstacles Encountered Completing the Research and the Role of the EP

In the previous chapter I alluded to the difficulties encountered whilst undertaking this research. The TaMHS therapists had questioned whether the correct procedure

had been followed and also highlighted their concerns regarding the overall ethics of an EP conducting research in the area of therapy which could potentially lead to children divulging confidential information (Appendix 7). During the many deliberations between the TaMHS therapists and local authority's EPS, the issue and the possibility of sensitive information being unravelled during my interviews with the children was raised. The TaMHS therapists argued that questioning children about their experiences of therapy risked opening up already covered wounds which in turn could lead to adverse emotional reactions in such children. There was also the question of whether a TEP first, could manage the potential emotional distress experienced by the children during interviews, and second, whether a TEP was aware of the steps to take afterwards to minimise the potential emotional stress caused by questions asked in the interviews.

In response to the first question it was obvious that there was a lack of understanding of the range and calibre of students accepted on to EP doctoral courses. All prospective EPs have had other careers working with children before being accepted on to the course and as TEPs we work with children all the time thereby increasing our experience and competence when it comes to working with children of all ages. I also stressed the fact that my research proposal had been passed by the two relevant ethics committees thereby highlighting the ethical nature of the proposed research. The importance of ethical considerations cannot be over-emphasised. Tindall (2002):

We need to be aware of the ethical implications for participants and researchers throughout the process of research, from planning through to outcome and sometimes beyond. Participants need to be protected from harm; their psychological well-being, health, values and dignity need to be preserved at all times

What Tindall (2002) states has relevance to the second point raised. As hitherto mentioned in this chapter, steps had been put in place to offer a debriefing session and time out to any pupil (in conjunction with their teacher) if the questions I asked caused undue stress. It must be emphasised once again that only the pupils who their teachers and parents thought were robust enough were put forward for me to interview. I was not interested in what was discussed during therapy; what I wanted to know was if they were aware of the reasons why they were referred to TaMHS and also their views about the therapies they had received. It is likely that the TaMHS therapists would have delved more deeply into the issues that were affecting them at the time. It also needs to be noted that there were no adverse reactions from the pupils after I had interviewed them and so there was no need to debrief them at the end of the sessions.

It would be wrong of me to blame the difficulties I had undertaking this research entirely on the TaMHS therapists. What transpired during our meetings was the fact that the therapists were not exactly sure what EPs do. Farrell et al (2006) point to the fact that even schools are not aware of the wide range of skills that are at their disposal especially in relation to working directly and therapeutically with children. Mackay (2007) too alludes to this and points out that in some quarters direct therapeutic work with children and young people is not viewed favourably. Dryden (1994) asserts that we equate psychological therapy to an intervention based on talking and listening rather than the use of medical or physical methods.

The government Green Paper on Special Educational Needs (DfE, 2011b) encourages EPs, in addition to their statutory role, to develop their profession in a

way that makes it more relevant and adaptable so as to meet the needs of its core client group. For this to be realised there has to be more of a focus on practical interventions within mental health and psychological well-being. The Green Paper further adds that this change can only happen if the EP profession shifts its emphasis from exclusively school-based work to early and effective therapeutic interventions both in and out of schools. This is in line with Dawson and Singh-Dhesi's (2011) evaluation of the CBII, a therapeutic resource in Leicestershire.

5.6 The Changing Role of the EP

Although the role of the EP has changed over time its core responsibility has been problem solving within the educational setting. Dawson and Singh-Dhesi (2010) illustrate this point further by stressing:

Educational psychology, with its emphasis on working in schools, has traditionally considered the child in a relatively narrow way. A child exists in the contexts of home, school and community. To enable the EP to effectively and most completely understand the child, he or she needs to understand the child or young person in these contexts

(Dawson and Singh-Dhesi, 2010, p.298)

This once again emphasises that social ecological paradigm which this thesis adheres to.

EPs have existed in many shapes and guises over time but not necessarily within the formalised profession as it is today. Kelly et al (2008) cite the origins of the profession right back to James Galton in 1884 and also to James Sully in 1886. There were parallel developments in America and Germany which also focused on children experiencing difficulties within schools.

Cyril Burt is accredited with being the first recognised EP in the UK. Burt saw the profession of the EP as a scientist practitioner interested in both qualitative and quantitative interventions that affect the child within the realm of education and the home. Frederickson et al, 2008) assert that:

Whatever the problem might be, instead of calling each child up into the office... I always found it far more effective to study him, as if it were, in situ, and of course that meant visiting him in school, calling him at home, and watching him with his play fellows larking in the streets

(Frederickson et al, 2008, p.7)

Although Burt represents the genesis of the profession one can extrapolate from his own professional practice core ideals and modes of practice that are incumbent and relevant for the educational psychology profession in the 21st Century. Observation, interviewing, testing, arriving at an hypothesis and a workable solution were the foundation and building blocks that were structured in the embryonic stages of the professional that still form the main tents of the profession today. Burt's starting point was to engage with and observe whichever child who presented some kind of perceived problem or deficit within the classroom. His remit was to apply psychological methods of enquiry to understand the ensuing problems and then using the relevant qualitative and quantitative methods to help advance the child's overall development. In finding solutions, Burt was able to locate the ensuing problems within the child's social context be it the home, the school or something inherent within the child's cognitive functioning processes. Burt looked for ecological reasons for the problems rather than just putting the responsibility for overall development on the child himself/herself. When juxtaposed with more recent

psychological practice one can note striking similarities. Beaver (2003), for example, states:

The basic starting point is that psychologists are involved in enhancing children's learning as opposed to identifying deficits, or problems, in functioning...The most productive problem to focus on is what the system of influential adults within the child's world can do to enable the child to make the most effective use of time they spend in education...

(Beaver, 2003, p.1)

Despite this, it is still the view of some professionals that our role and skills do not go beyond the prescribed duties within the paradigm of special educational needs detailed in the Special Educational Needs Code of Practice (DfES, 2001).

In 2006 the training of EPs changed from a one year Masters programme to a three year Doctorate. The change from a one year to a three year course and the admittance to the programme of students from teaching and non-teaching backgrounds has had a two-fold positive effect on the profession as a whole. First, the three year programme has and is producing research-savvy EPs into a profession whose methods and approaches are expected to be based on quantifiable evidence. Second, having a profession where specialisms reach beyond the confines of the school and the national curriculum has resulted in EPs having a role in other areas such as mental health, autism and looked after children, to name a few. However, extending one's sphere of influence beyond the school does have its drawbacks. EPs are now becoming involved in areas that were traditionally seen as the remit of other professionals. Mental health, for example, is an area in which clinical psychology and various psychodynamic therapists are known to have expertise in; looked after children is an area of work which is synonymous with

children and families social work. It is therefore not surprising that the therapists in the local authority thought it odd that a Trainee EP was evaluating the children's views of TaMHS therapeutic interventions they had accessed. Not only was the Trainee EP undertaking research, it was research into mental health two roles that have not been traditionally associated with EPs.

It is useful at this point to refer to insight into recent developments in mental health that have drawn on the expertise of the EP, for example, Leadbetter (2010) points out that:

Although many are convinced that EPs should not become therapists, there is a general acknowledgement that the profession should direct a proportion of its time to children with emotional difficulties and mental health needs. The rise of CAMHS and more recently TaMHS has ensured that children with early stages of emotion stress are more likely to be noticed and subsequently have resources allocated to them

(Leadbetter, 2010, p.274)

5.7 EP Practice in the 21st Century: Are We Still Relevant?

As indicated by Leadbetter's (2010) comment above, working between the CAMHS/TaMHS interface places the role of the EP firmly within the mental health paradigm. In other local authorities, TaMHS was either run by EPs or in conjunction with Clinical Psychologists, this is laudable because it shows that EPs do have a role within mental health and are able to work with other professionals in a collaborative way to bring about effective strategies and interventions in the lives of children and young people. Despite good ground breaking work being done by EPs working within mental health structures we cannot hide away from the fact that EPs are relatively

new-comers in the field mental health, they are following in the footsteps Clinical Psychologists and psychodynamic therapists. EPs work mainly within the psych-social model of disability but mental health, apart from TaMHS falls within the medical model, hence CAMHS and Clinical Psychologists are by and large based in clinic and hospital settings. While EPs and Clinical Psychologists may have common modes of working common the fact remains that they have different emphasises within their roles and are trained differently. Regardless of how diversified EPs' work is they carry out most of their work in schools not hospitals and clinics as is the case with Clinical Psychologists.

Although the SEN Green Paper on Special Educational Needs (2011b) encourages EPs to cast their net beyond their current statutory role the problem of carving a unique role remains.

Cameron (2006) emphasises the difficulties the EP profession has had finding their own niche within an environment of cuts and competing professions. However, he highlights the following as unique selling points EPs have to offer:

- Using models of psychology to solve human problems;
- Using psychology to uncover mediating variables;
- Understanding human interaction and problem dimensions using sophisticated models
- Using evidence-based research to inform practice as a catalyst for change
- Using psychology to promote big ideas in enabling clients to spot opportunities for positive change.

Although laudable, a critical examination of the points raised by Cameron (2006) will reveal that most applied psychologist could lay claim to the same professional

tenets. MacKay (2007) takes this argument further and emphasises the fact the vocational differences between the various applied psychologies in operation today are minimal as all these professions employ psychological models, theories and practice within problem-solving paradigms. In fact there was a time when there were no differences between the various psychologies as everyone entering the profession was trained generically and could transfer their skills from one specialism to another. The professional divisions we have in applied psychology today is the construction of the British Psychological Society. In order to make psychologists more attractive in the employment market psychology as a whole was demarcated into specialisms and that is why divisions in psychology such as clinical, educational, occupational, health, forensic, counselling and sports now exist. The problem today is that because each division now has its own training entry levels and specific curriculum such lateral movements between the professions have now been made difficult. Although the Health Professions Council (HPC) does not protect the titles of individual psychologies such as 'Educational Psychology' it does prefer the generic term 'Practitioner Psychologist'. This represents a shift from the specialist to the generic form of psychology which was the case before the BPS decided to categorise professionals into specific divisions. Is this now therefore a move back to having generic psychologists? Probably not and this is because outside the HPC the individual specialisms still remain. The BPS still retains the divisions and so do the various universities who train applied psychologists. Different funding routes into psychology training programmes also serve to maintain these divisions. The NHS, for example, only funds the clinical psychology training courses and up until very recently the Children's Workforce Development Council funded educational psychology training courses.

Regardless of the titles and entry into training courses it could be argued that the EP profession has always been in flux but it has adapted to its surrounding environment and developed. In some local authorities TaMHS have given EPs the opportunity to work directly and therapeutically with children experiencing emotional difficulties. This yet could be another reincarnation of the role of the EP.

5.8 Strengths and Limitations of the Research

The strength and weakness of research at doctoral level are strongly linked with the research methods used and the data that emerges from it is explained and discussed. As this research focuses on the constructions that people have of mental health and also the evaluations of children who had accessed TaMHS therapeutic interventions, interviewing three groups of participants enabled a wide range of perspectives to be collected and discussed. Furthermore, specifically asking children the reasons they thought they were offered therapy and their experiences of it empowered children to have their own voices listened to and heard by adults. Apart from my research there has been an evaluation of TaMHS in the local authority in form of an unpublished report (Evans, 2011). The report contained a few quotations from a small number of children regarding their thoughts about TaMHS but the evaluation in general was adult led and adult focused. My research however, addresses the whole issue of agency within professional and therapeutic interventions; this potentially gives children and young people a forum in which they can make their needs known, as exemplified in the extract:

We want to hear voices of young people, influencing and shaping local services; contributing to their local communities; feeling heard; feeling valued; being treated as responsible citizens.

(Children and Young People's Unit, 2000, p.20)

Apart from taking on board the views of the children this research also gives an insight into the views of the parents. Interviewing the children and not the parents would have left a big gap in the research because as the research has highlighted, the experiences of the child within the home and the environment where he or she lives has a direct impact on his or her mental health.

In Chapter 1, government initiatives such as SEAL, BEST and Extended Schools are mentioned and the importance of the school environment in the fostering of healthy lifestyles in children. A relative strength of this research, therefore, is that it takes on board the views of teaching staff who are expected to assume additional roles which take them from their traditional duties into the realm of mental health. This research therefore also gives teachers a voice and highlights their concerns regarding the paucity of training in mental health and the weight of expectation felt in having to become competent in identifying children with emotional difficulties in the classroom.

Overall, using thematic analysis to highlight the main tenets of the interviews with the three participant groups was an astute choice. I am aware that a mix methods approach is one favoured by many because it involves using the strengths of both qualitative and quantitative approaches and is therefore generally considered a more robust method when it comes to the collection, dissemination and interpretation of data. However, my rationale for adopting a wholly qualitative approach lies in the fact that the overall aim of the thesis centres on people's constructions of mental health and pupils' experiential evaluations of the therapies accessed. Quantitative approaches would not have furnished the research with the necessary information.

The authors further add that the focus on the experiential claims of the participants makes IPA different from discourse analysis. As I was particularly concerned with the constructions and the themes that emerged from both the literature and the interviews I felt it more appropriate to employ thematic analysis. In espousing the benefits of thematic analysis Braun and Clark (2013) stress that:

We view TA theoretically flexible because the search for, and examination of, patterning across language does not require an adherence to any particular theory of language, or explanatory meaning for human beings experiences or practices. This means TA can be applied within a range of theoretical frameworks, from essentialist to constructionist; thematic discourse analysis is even possible

(Braun and Clark, 2013, p.120)

Aside from the debate surrounding which method of analysis to use, it could be argued that there is a weakness in this thesis relating to gender. The adults interviewed, that is, the parents and the teaching staff, were all female and so my research is largely based on the constructions of female adults alone. A wider participant group may have contained males and so the juxtaposition of their constructions with that of the female participants could have taken place and perhaps enriched this thesis further.

Students undertaking academic doctorates, such as PhDs (Doctor of Philosophy) and DScs (Doctor of Science) as opposed to educational psychology professional doctorates, have at least three years of full time study in which to research a topic and complete a thesis. The research undertaken for this thesis did not start until I was in the second year of my doctoral programme and so the time needed to undertake a major piece of research was not available. Furthermore, the research was undertaken on a part-time basis because I was enrolled as a TEP at the time

within my local authority. Ideally the research undertaken would have been more rounded and better evaluated had a longitudinal study been undertaken. Edwards and Talbot (1997) explain that a longitudinal approach involves the development of research where data is gathered over an extended period of time. They explain further that the advantage of such an approach is that it allows a diary of activities to be collated at different periods of time and at the end of the data collecting process enables the researcher to plot the differences between and within cohorts. In my research pupils could have been interviewed before they had accessed the therapies available (the pre-patient/thesis phase), during therapy (the in-patient/anti-thesis phase), and after the therapy had been completed (the post-patient/synthesis phase). A main advantage of this approach may have been the fact that I would have been able to assess the short and long term effects of TaMHS therapeutic interventions within the post-patient phase. An argument to be made here is that without undertaking a longitudinal study whereby pupils' views and thoughts were assessed at different stages within the mental health process, an in depth evaluation cannot be said to have been undertaken.

Throughout this thesis I make claim to the fact that EPs should have a greater role in delivering therapeutic interventions within TaMHS and also within the profession as a whole. At the time of writing this thesis I was aware that the EPS in Norfolk had EPs delivering TaMHS interventions. It would have been apt had there been enough time to juxtapose or undertake a comparative study of TaMHS being delivered by therapists in my local authority with the same programme run by EPs. The true value of this juxtaposition would have been seen at the conclusion of TaMHS. Apart from the evaluations of both sets of pupils it would have been apt to find out if the EPs continued with the therapies after TaMHS had ended and the benefits this brought to

the pupils. It is worth pointing out though that EP involvement within therapy should not just occur just because a person has completed his or her doctoral degree.

Evans et al (2012) raise the issue that even though there are high values held within the three year doctoral programme; they question whether the degree programme can keep up with the constant flux within education. This in mind, they question whether the three year doctoral programme is still fit for purpose. This thesis would have benefited more from focusing more on this aspect of EP training.

I have explained the difficulties that occurred with the TaMHS therapists during the process of completing this research, however, what I did not cover were their views and constructions of mental health. Not doing so, in my opinion, leaves an important gap because they were the only relevant group of adults not interviewed. It must be stated clearly that the reasons why I did not interview the therapists were two-fold: (1) there was not enough time to interview them and, (2) I was not sure that they would be able to give me the information needed because of their confidentiality clause within their professions.

The overall ethical considerations in this thesis could and should have been afforded much more rigour. The letters I sent to the schools, for example, (Appendix 2) asking if they were willing to partake in my research is an obvious limitation of this thesis because the wording of it suggests that the research would be skewed from the outset and thereby engendering a researcher bias. In the letter I state:

I am aware that I will not be able to interview all the children and this invariably will skew the overall results. I do however believe that getting the views of just a small sample of children will help relevant professionals and authorities tailor their resources to meet the specific needs of certain children better

I should have been more careful by adopting a more neutral tone. Furthermore, as I was undertaking qualitative and not quantitative research the issues of participant numbers and the skewing of the results should not have arisen in the first place.

As already stated in the 'Reflective Analysis' section, making the issue of the potential sensitivity of my research should have been made much clearer from the outset, furthermore being clearer about the process of recording and transcribing of interviews should have been made much more apparent in the overall research process. Addressing all these issues from the outset would have made the overall ethical considerations given to this research more robustness.

5.9 Implications for Further Research

Various government initiatives and policies within education such as SEAL and TaMHS allude to the importance of children's mental health. If optimum learning is to be achieved in classrooms then children will need to be both physically and mentally healthy. What this research highlights is that although such policies and initiatives suggest a growing awareness among policymakers of the importance of mental health, they could still be accused of apparent short-sightedness. As it has been mentioned on numerous occasions throughout this thesis, TaMHS was originally conceived as three year project and yet local authorities, and invariably schools have not been given tangible replacements in the form of extra funding to ensure that children in mainstream schools have a present, long term and effective resource to access at their time of emotional need. This scenario points to the fact that such children who have accessed TaMHS need to be followed up to see whether their mental health has improved over time, and also to assess the innovative ways local authorities and schools have employed in meeting the emotional needs of these

children as a way of filling the void left by TaMHS. As mentioned during various parts of this thesis, EPs given the right training are firmly placed to fill in the gaps.

A comparative study involving children and young people who have assessed therapeutic interventions and support through TaMHS and CAMHS would be apt. CAMHS is a NHS resource whose funding is not time restricted. Invariably it means that children and young people who have accessed CAMHS may, in theory, be re-referred if the need justifies further interventions. Such a study would highlight which model of intervention is more effective: (1) short and single block sessions, which was the TaMHS model, or (2) potentially longer and multiple block sessions which is the CAMHS model.

In this research, the effectiveness of the different types of therapeutic interventions was not evaluated. As the government's preferred method of therapeutic intervention is CBT due to its relatively vast evidence base; it would be apt to have undertaken research into other forms of non-pharmacological interventions so that their emerging database could be juxtaposed against CBT in order to evaluate their effectiveness and accessibility. SFBT would have approach to compare with CBT

This research has highlighted the importance of mental health initiatives within schools; however, such initiatives need to be long term. Three year programmes such as TaMHS offer a very short injection of resources but does not guarantee continuation. This means that the gains made during such short programmes are easily lost, not because of the lack of expertise in the area of mental health but the paucity of funding within special educational needs.

Chapter 6

6 The Conclusion

This research has been an exposition of the views, perspectives and constructions of those closely involved within the structures of mental health in schools. Teachers have highlighted the importance of resources like TaMHS but at the same time have voiced their concerns about the added and imposed responsibility they have within mental health without having the consummate skills and training to go with it. Such lag brings into question the long term effectiveness of the Extended Schools programme. Teaching staff in schools have been given extra functions beyond their fundamental teaching roles, this includes the identification of emotional difficulties in children within the school environment. At a time of government cuts and the increasing pressures schools face in the light of SATS and league tables, teachers are being expected to adopt a parental role as part of their core duties within the paradigm of learning.

The central premise of the government's publication: 'No Health without Mental Health' (DoH, 2011) is the centrality of mental health within the overall general health paradigm. The creation of TaMHS is a good example of this premise. The cessation of TaMHS in a number of local authorities when the central government funding expired in 2011 brings into question the government's commitment to mental health for children. As mentioned in this thesis, TaMHS straddles areas related to both health and education however, with budgets cuts it is unlikely that one governmental department would want to take long term responsibility for it. Children in schools do not necessarily need an exact programme named TaMHS to meet their emotional health needs but some appropriation of the programme whereby schools in general

and not only those in deprived areas are able to access therapeutic interventions on a long term basis is necessary. In the government publication: Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011 (DfE, 2011a) the long term need for such provision is intimated:

It may be helpful to ensure that in any future roll out of mental health provision in schools attention is paid to ensuring a common language and as full integration as possible of services in schools. When implementing interventions such as this one on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and to how such support can be sustained

(DfE, 2011a)

Sustenance of support suggests the implementation of long term mental services that schools can access, this in reality has not really happened after the cessation of central funding for TaMHS.

Parents have shown their value within the paradigm of mental health. Involving parents in the research has shed light on the difficulties their children have experienced at home and how these experiences have affected both their emotional well-being and academic performance at school. As Bronfenbrenner (1979) has noted, homes are an integral part of the social ecological system; any change to the home environment affects the child in school. Homes and schools are therefore inextricably linked and so effecting positive change in one area and not the other has been proven to be ineffectual.

A main aim of this research has been to give children a voice regarding their experiences of therapeutic interventions and also their thoughts and perspectives regarding the difficulties they face both at home and in school. In doing so it has

been possible to highlight the importance of the agency of the children within learning and mental health paradigms. Although they spoke positively about the therapeutic interventions accessed, it is apparent that their agency within the process of mental health, that is, from the in-patient phase through to the post-patient phase involved minimal agency on their part. For interventions to become even more effective children need to be engaged with more right from the very start.

TaMHS in my local authority saw EPs more in a removed management role rather than active agents in the delivery of therapeutic interventions. If EPs do not overtly establish themselves as competent professionals capable of providing therapeutic interventions for children and young people then the profession may be in danger of becoming sidelined in the ever-changing work of multi-agency interventions.

Atkinson et al (2011) argue that historically EPs have been at the vanguard of therapeutic interventions. They urge EPs to return to their professional roots by taking on a more central role in the delivery of therapeutic interventions. The authors are, however; less sanguine about the reality of this happening soon because of the statutory role they have been required to take on:

The impact of SEN legislation in the 1980s and 1990s resulted in greater emphasis on psychological assessment within the EP role and a view that such work prevented from fully utilising their skills in applying psychology and making more effective contributions through development of other areas of their work

(Atkinson et al, 2011, p.161)

This research has also highlighted the importance of multi-agency partnerships and the need for therapists to become part of the professional loop if children are to access streamlined services. The issue of therapist/client confidentiality need not be

an impediment towards working effectively with children as all relevant professionals work within the confines of confidentiality but are able to find common ground with others in order to provide an effective service for children.

Undertaking research in this area has brought about a number of different experiences some negative but mostly positive. If I were to undertake research in this area again there would be some things that I would do differently, for example I would be more stringent when it comes to the matter of ethical considerations. There are also some things that I will build upon because, in my opinion, some invaluable information has been derived from it, for example, highlighting the views of children.

Perhaps there needs to be a change in the way current EPs are trained. The combination of being an EP and also a research student does have some drawbacks; one of them being the paucity of time needed to complete a doctoral thesis. Notwithstanding, this has been a worthwhile experience for me in that the EPS will be able to reflect on my findings and improve the way therapeutic interventions are delivered in schools.

Glossary

AEP: Association of Educational Psychologists

ADHD: Attention Deficit Hyperactive Disorder

ASD: Autistic Spectrum Disorder

BESD: Behaviour, Emotional and Social Development

BEST: Behavioural and Emotional Support Teams

BME: Black and Ethnic Minorities

BSS: Behaviour Support Service

BPS: British Psychological Society

CAF: Common Assessment Framework

CAMHS: Child and Adolescent Mental Health Service

CAST: Child and Adolescent Support Team

CBII: Child Behaviour Intervention Programme

CBT: Cognitive Behavioural Therapy

CIN: Child in Need

CP: Clinical Psychologist

CPD: Continuous Professional Development

CPR: Child Protection Register

DoE: Department of Education

DoH: Department of Health

DCSF: Department of Children Schools and Families

DfEE: Department for Education and Employment

DfES: Department for Education and Skills

DSM: Diagnostic and Statistical Manual of Mental Disorders

EBD: Emotional and Behavioural Difficulties

ECM: Every Child Matters

EMDR: Eye Movement Desensitisation Reprocessing

EP: Educational Psychologist

EPS: Educational Psychology Service

ERIC: Educational Research Information Centre

GP: General Practitioner

IPA: Interpretive Phenomenological Analysis

LSS: Literacy Support Service

NASUWT: National Association of Schoolmasters/Union of Women Teachers

NHS: National Health Service

NICE: National Institute for Clinical Excellence

Ofsted: Office for Standards in Education

ONS: Office of National Statistics

PATHS: Promoting Alternative Thinking Strategies

PEP: Principal Educational Psychologist

PHSE: Personal, Health and Social Education

PTSD: Post Traumatic Stress Disorder

SATS: Standardised Achievement Tests

SDQ: Strength and Difficulties Questionnaire

SEAL: Social and Emotional Aspects of Learning

SIT: Social Identity Theory

SEN: Special Educational Needs

SENCo: Special Educational Needs Coordinator

SCC: Safeguarding Children Conferences

TA: Thematic Analysis

TAC: Team around the Child

TAS: Team around the School

TaMHS: Targeted Mental Health in Schools

TEP: Trainee Educational Psychologist

SEBD: Social and Emotional Behavioural Development

SFBT: Solution Focused Brief Therapy

UNCRC: United Nations Convention on the Rights of the Child

UNICEF: United Nations Children's Fund

UK: United Kingdom

VCR: Vulnerable Children's Register

WHO: World Health Organisation

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Appendix 1

UEL Research Ethics Committee Approval



Mark Turner
School of Psychology
Stratford

ETH/12/93

25 August 2011

Dear John,

Application to the Research Ethics Committee: The construction of Mental Health in Everyday Life: How children in Medway evaluate TaMHS⁺ therapeutic interventions (R Estee-Wale)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Admissions and Ethics Officer
Direct Line: 0208 223 2976
Email: d.dada@uel.ac.uk

Research Ethics Committee: ETH/12/93

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date:

Please Print Name:

Appendix 2

Letter to TaMHS School

Please contact: Ricardo Estee-Wale
Your ref:
Our ref:
Date: 25 October 2010

Children and Adults – Learning Partnership

Heidi [REDACTED]
Headteacher

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dear Heidi

I am a final year trainee educational psychologist who with the agreement of Medway Council and the University of East London has been given the task of evaluating the TaMHS project in Medway from the perspectives of children. The title of the project is 'The Construction of Mental Health in Everyday life and how Children's [REDACTED] Evaluate TaMHS Therapeutic Interventions'.

I am aware that your school is one of the pilot areas of study and so I would be grateful if I could speak to some of your children (perhaps one or two) – with permission from them, their parents and the school. I am aware that the time of children within school is structured and so I endeavour to be as flexible as need be so that their timetable is not disrupted.

I am aware that I will not be able to interview all children and so this invariably may skew the overall results. I do however believe that getting the views of just a small sample of children will help the relevant professionals and authorities tailor their resources to meet the specific needs of certain children better.

I would be very grateful if I could use your school as part of the evaluative process.

For further information I can be contacted via this number: [REDACTED].

Yours sincerely

Ricardo Estee-Wale

Appendix 3

Parental Consent Letter

Dear Mrs M. . .

I have been commissioned by Midway Council and the University of East London to undertake an evaluation of TaMHS but from the perspective of the child.

I would be grateful if you grant me consent to record your child's views for the purpose of this project. All I would be asking is that your child relays to me his/her experience of the therapeutic intervention received and the reasons why he/she feels she was put forwards in the first place.

The questions asked during the short interview are designed in such a way that no sensitive or potentially upsetting information will be sought. If your child does however, show signs of discomfort, the interview will be ended immediately and with a short debrief.

Although your child's contribution will be anonymised, the information gathered will form a very important part in the evaluation of TaMHS which in turn will help improve the service.

Please complete the form below and return to Stoke Community School as soon as possible.

Thank you for taking time to consider my request.

Dr Ricardo Estee-Wale

Trainee Educational Psychologist

I give permission for my son/daughter* _____ to be interviewed by Dr
Estee-Wale about the TAMHS project.

Signed _____ Name _____ Date 14/12/10.

* please delete as appropriate

Appendix 4

Parent Request Letter

Dear Parent,

Thank you very much for allowing me to interview your child in relation to my TaMHS project.

I would also like to hear the views of parents regarding their children's access to TaMHS and so I would be grateful if you would be willing for me to interview you.

The interview will be very short. If you would like to take part please inform the school's head teacher so that we may arrange a convenient time for the interview to take place

Regards

Dr Ricardo Estee-Wale (Trainee Educational Psychologist)

Appendix 5

TaMHS Questions

Parents

Teaching Staff

Pupils

Interview Script

Parents

My name is Ric and I am a Trainee Educational Psychologist working with...Thank you very much for agreeing to take part in my research and also for allowing me to interview your child. As a Trainee Educational Psychologist I adhere fully to the British Psychological Society's Code of Ethics, this means that whatever you say to me within the interview will be treated in the strictest confidence; your confidentiality will be upheld. If I decide to use any of the information you have given to me I am bound by the BPS Code of Ethics to ensure that no actual names are mentioned. This means that you will be anonymous; neither your name nor anything else that can be used to identify you will be revealed.

As Mrs...has informed you about my research and in discussion with you, you both believe that your child will be able to cope with the questions that I shall be asking. I will be asking your child about the problems he/she experienced at home and the difficulties faced at school. Ultimately the questions will revolve around the reason(s) your child was referred to TaMHS and how they felt that they coped with the therapy given. Although the questions asked may be of a sensitive nature I have a duty care to ensure that no distress is caused to your child during the interview process. If I see any sign that your child is feeling uncomfortable the interview will be stopped straight away and his/her teacher will be informed so that a debriefing session can take place afterwards with me, your child and his/her teacher. I do not envisage this happening but once again the BPS Code of Ethics dictates that I have a duty of care towards my participants. You will be informed on the day by his teacher regarding how the interview went. Please inform your child that if he/she she does not want to

be interviewed on the day he/she is not obliged to do so and if he/she decides to start the interview but wants to pull out during it please advise him/her that she is free to do so and will not be told off for doing so

Your interview will be a short one and should last about 10 minutes long; you can withdraw your consent at any time, this means that if you feel that you want to withdraw from this interview please do so. I will stop the recording and then delete everything you have said. Please note that this extends to your child as well. If you want to withdraw your child from the research everything that has been recorded will be deleted and not used.

Once again than you for agreeing to be interviewed as your views should help give me a better understanding of the difficulties your child experienced before becoming involved in TaMHS.

Proposed TaMHS Questions

Parents

In your own words, why do you think that your son was referred to TaMHS?

What is your understanding of the specific problems that were affecting your child at school?

What are your views about your children being referred to TaMHS?

TaMHS is about 'mental health', does this term put you off?

Interview Script

Teaching Staff

Thank you first of all for agreeing to take part in my research and also highlighting the pupils who you feel might be able to take part. Thank you also for informing their parents about my research and gaining their consent for me to interview their children.

As we have discussed previously, my research centres on TaMHS and the various perspectives people have about mental health. I will be asking you a series of questions relating to the child/children accessing TaMHS and also your views regarding mental health.

As a Trainee Educational Psychologist I fully adhere to the BPS Code of Ethics, this means that whatever you say to me within this interview will be treated with the strictest confidence; your confidentiality will be upheld. If I decide to use any of the information you have given to me, I am bound by the BPS Code of Ethics to ensure that actual names are not mentioned. This means that you will be made anonymous as neither your name nor your school will be revealed.

In accordance with the BPS, I have a duty of care towards you. Please note that you are free to terminate the interview at any time and if you do choose to do so everything recorded will be deleted and will not be used in my thesis.

Once again thank you for your time and effort.

Proposed TaMHS Questions

Teaching Staff

Tell me about your school and the demographics from which most of your children come from

What are the issues within the family that you are aware of which may have had an impact on their emotional well-being

What were the observed behaviours within the school/classroom/playground?

Why were each of the pupils to be interviewed referred to TaMHS specifically?

Do you think that teaching staff in general are equipped enough to identify mental health difficulties in children?

What has been the progress of (name of pupil) since TaMHS interventions?

Do you think that mental health provision should be based within or outside of school?

If TaMHS were to continue would you refer more pupils?

Interview Script

Pupils

Hello... my name is Ric, I am training to become an educational psychologist. An educational psychologist is a person who helps children who are finding things difficult in school. It could be helping children who are finding it hard to learn things at school or children who are finding it hard to makes friends with others. There are other things that I do but I do not want to take up too much of your time.

Your mother and your teacher have explained to you that I will be asking you questions about some of the problems you have had in school. I will also ask you about the help you have received.

Thank you for agreeing to meet with me. I am going to ask you a few questions. If you feel that you cannot answer my questions you do not have to. Also please note that you can leave this room at any time; you will not be in trouble if you do so. If you choose to leave before the interview has finished I will let your teacher know so that we can have a little chat to see if you are alright. If I feel that you are finding the questions difficult I too will stop the interview and stop recording. Everything that you have said to me will be deleted and not used in my research.

If I choose to include anything you tell me in my research I will make sure that your real name is not used, I will also make sure that the name of your school will not be mentioned either. Do you understand everything I have said?

Once again, thank you for agreeing to take part in my research.

Proposed TaMHS Questions

Pupils

Tell me about yourself

What are the things you like about home?

What are the things you don't like about home?

When you were having problems at home/school how did you feel?

Someone was working with you when you had these problems. What work did you do with this person?

How did you feel after you had reflexology/play therapy/art therapy...?

Appendix 6

Examples of Coded Interviews

Interview with Parent B

Interview with SENCo Sparrow School

Interview with L (Robin School)

Parent B (Coded Interview)

Parent of B	Code	Sub-theme	Theme
Interview line, 16	My lad getting into a lot of trouble	Response to child's behaviour	Parent's awareness of son's of issues
Interview line 17	Professional types	Professional help needed	Parent's awareness of issues
Interview line18	How can my lad be helped	Awareness of problems	Parent's awareness of issues
Interview line 27	When his friend died	Awareness of problems	Parent's awareness of issues
Interview line 28	His friend's death	Awareness of problems	Parent's awareness of issues
Interview line 29/30	Chance to say goodbye	Release of emotions	Role of school
Interview line 30/31	He became more within himself	Reaction to death	Behaviour
Interview line 31	I asked if things were alright...	Parental concern	Exploration of issues
Interview line 32	He started becoming obsessed with death	Reaction to death	Anxiety
Interview line 33/34	He started asking questions...	Reaction to death	Anxiety
Interview line 34/35	He started seeing death everywhere	Reaction to death	Anxiety
Interview line 35	I took him to the doctor	Parental concern	Parent's awareness of issues

Interview line 36	I decided to tell his teacher	Parental concern	Parent's awareness of issues
Interview line 37	Information about therapies	Offer of help	Role of school
Interview line 38/39	He wasn't able to share his deepest thoughts	Limitation of parent's ability to help child	Behaviour
Interview line 41	Going through emotional problems	Awareness of problems	Construction of mental health
Interview line 41/42	He had problems before...	Parental concern	Parent's awareness of issues
Interview line 42	...when his dog died	Awareness of problems	Behaviour
Interview line 45	None of us could get him out of it	Parental concern	Behaviour
Interview line 46	He has problems with his ears	Awareness of problems	Comorbidity
Interview line 48	He'll scream the place down	Reaction to noise	Behaviour
Interview line 51	He certainly has emotional problems	Parental concern	Construction of mental health
Interview line 52	We should take him to the doctor	Parental concern	Parent's awareness of issues
Interview line 52/53	..give him something that will help him	Parental concern	Parent's awareness of issues
Interview line 54/55	Too shy to talk to talk to us	al concern	Behaviour
Interview line 55	When I spoke to	Parental	Role of school

	the teacher	exploration	
Interview line 55	She had seen some changes in his behaviour	Teacher's views	Role of school
Interview line 56/57	He was being lippy in class, he just didn't seem himself	Reaction in class	Parent's awareness of issues
Interview line 57/58	We were told that some sort of therapies were available	Information	Role of school
Interview line 61	We were grateful for it, we knew we needed outside help	Reaction to help offered	Role of TaMHS
Interview line 61/62	We wanted the best for him	Reaction to help offered	Role of parent
Interview line 65	Not really. As long as he got the help	Reaction to mental health label	Attitude to mental health

SENCo (Coded Interview)

SENCo H	Code	Sub-them	Theme
Interview line 11	As you may well know we are in the poorest area of...and with it comes its own peculiar issue	Where we are situated	School's location
Interview line 12,13	Many of our children live in homes that are on or just above the poverty line. Many of our parents are unemployed	Description of families	Socio-economic status
Interview line 13,14	We have a very high proportion on one parent families	Description of family	Family situation
Interview line 15	A more accurate term is single mum families	Description of family	Family situation
Interview line 15,16	These mums have partners or ex-partners who do very little in the raising of their children	Burden on the mothers	Family situation
Interview line 16,17	We have families fleeing from domestic violence and some where domestic violence is apparent	Domestic violence	Family situation
Interview line 17,18	In our school we only have a few children who do not on rough council	Poor accommodation	Family situation

	estates of appalling rented accommodation		
Interview line 19,20	In short most of our kids are known to Social Services for one thing or another	Involvement of other agencies	Social Services Involvement
Interview line 22,23	We have a Vulnerable Children's Register which highlights children's emotional and social needs	Criteria for TaMHS	Labelling
Interview line 23,24	If there is a change in their behaviour we know there is a lot of things going on outside the school	Change in behaviour	Family situation
Interview line 26,27	I think that it is your ability to function on a day to day level		Construction of mental health
Interview line 31	A lot of children feel over-burdened with responsibility	Stress on children	Anxiety
Interview line 31,32	For example, being worried about their mothers who have been subjected to domestic violence	Stress on children	Family situation
Interview line 33,34	I don't think that children have the resilience to cope with what they have witnessed		Emotional state

Interview line 34,35	Trouble at home soon becomes trouble in school; you can see it in their behaviour	Deviant behaviour	Change in behaviour
Interview line 35,36	Sometimes it's rudeness to staff or aggression towards their peers	Deviant behaviour	Change in behaviour
Interview line 36,37	Most of the time we would be with our right to exclude them	Exclusion	Role of the school
Interview line 37,38	Back home where the problems started in the first place?	Limited effect of exclusions	Family situation
Interview line 38,39	These children can't cope because their parents can't help them...	Coping strategies	Emotional state
Interview line 39,40	Such children tend to have low self-esteem and have no strong friendship groups	Social difficulties	School's awareness of issues
Interview line 42,43	In terms of JD it was her relationship with her peers and she always struggled with her work but did not want help	Unable to make friends; finding work difficult	Difficulties in class
Interview line 44,45	G is new to school and so did not have friendship support he was isolated and was making very little	Social difficulties	Friendship group

	progress in class		
Interview line 46,47	He had witnessed so much domestic violence at home that his mother had to run away...	Result of domestic violence	Family situation
Interview line 48,49	The feeling of fear and instability must have had a negative hold on him	Child's emotional state	School's awareness of issues
Interview line 53,54	It could be poor self-esteem, children being overtly unhappy in school and other emotional behaviours that draw our attention	Children's emotional state	Labelling
Interview line 56,57	It's been brilliant! The way they have been able to help children has made a noticeable difference in them	TaMHS is a positive resource	Effectiveness of TaMHS
Interview line 57,58	The only problem we have with TaMHS as you know is its short life span	Limited resources	The need for TaMHS to continue
Interview line 58,59	We are coming to the end of the three year pilot and we don't know what will be put in its place when it ends	Concerns about the future	The need for TaMHS to continue
Interview line 59, 60,61	It is beneficial to the children using it...because a	Effects of therapy on children	Effectiveness of TaMHS

	settled child does make the learning environment		
Interview line 62,63	Because we have no spare rooms in our school our children using TaMHS have to go out of school to access it	The need for TaMHS to be on site	Disruption to education
Interview line 63,64	It takes time out of learning and this affects their education	The need for TaMHS to be on site	Disruption to education
Interview line 65,66	HR and JDE are good at keeping the school involved	Sharing information	Role of TaMHS therapists
Interview line 69,70	The parents are not always proactive in engaging with TaMHS though	Partnership with therapists	Parents' attitude towards TaMHS
Interview line 70,71	The only part of TaMHS that has not been useful concerns vulnerable children going from primary to secondary school	Transitions	Limitation of TaMHS
Interview line 76,77	In JD we have seen a marked improvement in her attitude towards school, friends. She seems happier...	Change in Behaviour	Effectiveness of TaMHS
Interview line 78,79	She now has the emotional	Change in behaviour and self-	Effectiveness of

	intelligence to resolve things affecting her	esteem	TaMHS
Interview line 81	G is a lot calmer and has a settled friendship group	Change in behaviour and self-esteem	Effectiveness of TaMHS
Interview line 82	He still has some anxieties	Problems still persist	Anxiety
Interview line 85,86	HR the play therapist, we've mostly had play therapy, she does the SDQs. Four of our children have had art therapy	Art therapy	Role of TaMHS therapist
Interview line 88,89	It's easier for us if it was based in school and perhaps better for the child if he or she could go off the school site and come back	The need for TaMHS to be off site	Location of therapy
Interview line 90,91	Having TaMHS available is fantastic because it's like having a rapid response team. You can wait ages for CAMHS	TaMHS, an immediately available resource	Effectiveness of TaMHS
Interview line 93,94	It would be a great shame if it were not to continue. I still have more than 60 children who would benefit from TAMHS	TaMHS a limited resource	The need for TaMHS to continue
Interview line 94,	(The LA) needs a common approach	Streamlined mental health resource	Partnerships in mental health

95,96	to mental health in school; we should all be working together, no silos	needed	services
Interview line 96	The primary job of teachers is teaching	Teaching	Role of the teacher
Interview line 96,97	For children to learn their emotional and social needs have to be secure	Emotional security	School's awareness of issues
Interview line 97,98	There needs to be more children's centres to cope with these needs	More resources needed	School's awareness of issues
Interview line 98,99	We as teachers cannot provide that extra emotional support	Limitations to what teachers can do	Role of the teacher
Interview line 99, 100	We do not have the time and second we do not have the training	Limitations to what teachers can do	Role of the teacher
Interview line 100, 101	Most of our staff after their degrees went on a one year PGCE course	Limitation to what teachers can do	Inadequate training
Interview line 101, 102	Do you know how much time was devoted to mental health in school? One lesson if you were lucky	Ditto	Inadequate training
Interview line 102, 103,104	I do not object to teachers becoming involved in mental health...substantial	Further training needed	Changing role of the teacher

	training and a reduced work load		
Interview line 107	G is living with mum at the moment. Mum and dad went through a messy divorce	Living arrangements	Family situation
Interview 108	They left London because the home situation was quite violent	Domestic violence	Home situation
Interview line 109, 110	It was very stressful for them	Emotional state	Home situation
Interview line 110, 111	He took on the role of the class clown	Behaviour	Coping strategy
Interview line 112	This instigated play therapy	Behaviour	Role of TaMHS
Interview line 114	Mum has complex mental health issues	Additional factors	Mental health needs
Interview line 114, 115	She was neglected because of her mum's own needs	Capacity to care	Family situation
Interview line 116	She would come into school with head lice and was quite smelly because she hardly ever washed	Neglect	Family situation
Interview line 120	...whether she has a slight form of autism	ASD	Comorbidity

Pupil L, Robin School (Coded Interview)

Location	Quote/Code	Sub-theme	Theme
Interview line 15-19	I like history because we get to learn about the ancients	Favourite subjects	Attitude towards school
Interview line 21	I like playtime	Positive aspects of school	Attitude towards school
Interview line 23	...and lunch time	Positive aspects of school	Attitude towards school
Interview line 36	Usually writing...or it is one thing, a really noisy classroom	Negative aspect of school	Difficulties within the classroom
Interview line 40	It gives me a headache, I don't like it when teachers talk for ages	Negative aspects of school	Difficulties within the classroom
Interview line 44	Assembly! You have to sit for about 15mins just listening to someone talk	Negative aspects of school	Difficulties within the classroom
Interview line 48-49	Yeah, I can watch films because there is action in them but teachers...	Negative aspects of school	Difficulties within the classroom
Interview line 56-58	She probably thinks I'm a good kid. I don't really get up to mischief...	What my teacher thinks of me	Self-reflection
Interview line 62-65	Home, I like the place where I live...	What my home is like	Attitude towards home
Interview line 67	Usually just on the weekend. If I'm not	Relaxing at home	Attitude towards home

	going anywhere I'll sit in my pyjamas		
Interview line 74-75	Oh, my step-brother and sister, being told off for something I didn't do...	Anger towards siblings	Relationship with siblings
Interview line 79	Yeah, mum and dad are all right	Feeling towards parents	Relationship with parents
Interview line 81	I've got a step-dad where I live	Family set up	Family situation
Interview line 86	They had an argument	Parental discord	Family situation
Interview line 88	They had loads	Parental discord	Family situation
Interview line 90	Then they got back together and split up...	Parental discord	Family situation
Interview line 95	Anxious and a bit upset	Reaction to family discord	Anxiety
Interview line 97	Upset, probably angry...and I get upset when people are making a lot of racket	Reaction to family discord	Family situation
Interview line 100	Usually I just shout	Reaction to family discord	Self intervention
Interview line 102	And that usually stops them. That did stop them once	Reaction to family discord	Self intervention
Interview line 111	Usually shouting at each other	Parental discord	Family situation
Interview line 119-120	The main problem I am having now is my step-brother...	Feelings towards siblings	Relationship with siblings

Interview line 122	My step brother just eggs me on...	Feelings towards siblings	Relationship with siblings
Interview line 124-127	No younger. So he acts really cocky...	Feelings towards siblings	Relationship with siblings
Interview line 129,130	She usually just smacks me and throws things around the room...	Feelings towards siblings	Relationship with siblings
Interview line 139	Usually bored and upset	Reaction to problems	Self-reflection
Interview line 143-146	If they wind me up to a certain point I will lash out back...I just want to throw him down the stairs and kill him	Feelings towards siblings	Relationship with siblings
Interview line 160	I was doing foot massages	Reflexology	Type of therapy
Interview line 168/169	Usually I got a free foot massage, nice cream that smells really relaxing. I nearly feel asleep	Reflexology	Effects of therapy
Interview line 179	Still relaxed	Reflexology	Effects of therapy
Interview line 185	Yeah, it improved me	Reflexology	Effects of therapy
Interview line 187/188	Although I think that I am a lot calmer now, I still lash back...That will never improve	Limitations of therapy (reflexology)	Self-reflection
Interview line 194-196	...So my mum was saying maybe if I don't do my home work they'll put me in a boxing club	Sports	Extra curricula activity

Interview line 199	Yeah, because they wind me up	Feelings towards siblings	Relationship with siblings
Interview line 201/203	I snapped all the guitars I made	Breaking things	Reaction to stress
Interview line 208	It's mainly winding me up or it may be because they've nicked something of mine	Feelings towards siblings	Relationship with siblings
Interview line 209	Once my step-brother nicked my boxing gloves. I went ballistic	Feelings towards siblings	Reaction to stress
Interview line 215	Yeah, he nicks a lot of things, and when I am older I'll send him to prison	Feelings towards siblings	Reaction to stress
Interview line 223	Sometimes he annoys me	Feelings towards step parent	Family situation
Interview line 225-227	It's just that if it is C that needs to get told off, he'll tell me off as well	Feelings towards step parent	Family situation

Appendix 7

Therapists' Written Objection to Research

Letter of Response from UEL

TaMHS Meeting (Minutes)

Documents

1. Memo from KP to NM dated 11/01/11 – attached copy of letter from Ricardo to Mrs M.
2. Email from HB to NM, KP cc. SE 20/01/11.
3. Email from KP to NM cc. SE HB 20/01/11.
4. Email from KP to NM 21/01/11.
5. Email from HB to NM and KP 25/01/11.
6. Email from KP to NM cc. HB 26/01/11.
7. Email from KP to NM cc. HB, SA, JM 28/01/11.
8. Email from KP to NM cc. HB, SA, JM 28/01/11.

Issued Raised

1. (i) Has manner by which the trainee Educational Psychologist went about obtaining parental consent had a direct effect on the child not being able to access therapy?
- (ii) Was the disclosure of the child's personal information to a third party done in accordance with the Data Protection Act 1998?
- (iii) Is it appropriate for the EPS to contact a child's parent directly to obtain consent? (or would it be more appropriate if done by TAMHS?)
- (iv) Should a request for consent for a child to be interviewed as part of the TaMHS Project evaluation be made before a therapeutic intervention has commenced?
- (v) Would the "child interview" lead to the child disclosing details of their therapy that they should not have to do?
2. (i) Inaccuracy in letter to Mrs M stating that the research was part of the TaMHS evaluation.
- (ii) Suggestion that no contact is made with parents of ongoing TaMHS clients because the contact might have an adverse affect on the therapeutic intervention should the child be told that someone will be talking to them about their therapy whilst it is ongoing.
3. (i) Concern that "TaMHS" consent does not cover trainee's research.
- (ii) Concern that telling a child someone may speak to them about their therapy may have an adverse effect.
4. (i) Request to know which parents have been approached.

- 5.(i) Quote from UKCP Code of Ethics that that psychotherapists must clarify with clients the nature, purpose and conditions of any research with clients, noting TaMHS current consent covers only SDQs.
- (ii) Any interviewing of a client goes against the PTUK/BACP/UKCP ethical principles of trust, autonomy, beneficence etc.
- (iii) This is more so the case if the client is approached without having had the chance to be made aware of this and discuss it with their therapist.
- (iv) The Medway Council ethics committee has chosen to ignore the breaches above.
- (v) Recourse should be sought from Professional Bodies.
- 6.(i) Request for a delay in research whilst responses are sought from Professional Bodies.
7. Onside is a member of BACP whose guidance on research includes.

"36. The Association.....affect client".

 - (i) Have the two ethics committees, Medway Council and UEL, followed this guidance?
 - (ii) Is informed consent required from the client no matter what their age?

There are eighteen issues.

An initial response is as follows:

- 1.(i) If the child is not able to access therapy then that is because of his mother's decision.

It is a matter of opinion whether this was her decision solely influenced by the letter from the trainee educational psychologist or whether it was the trigger and there were other motivating factors.

- (ii) If one presumes that the third party refers to the trainee, then we know that the decision to refer was taken at a multi-agency meeting. We also know that the purpose of the meeting is to share information for the benefit of children's welfare and as such meets our professional obligations.

- (iii) This is a matter of judgement, though on balance from contact from TaMHS about research into TaMHS is more likely to reduce objectivity in response.

- (iv) This is a matter of judgement. Superficially, consent for a research interview has no bearing on the therapeutic intervention.

- (v) Certainly it may allay concerns if the nature of the interview is made known to TaMHS staff. See also 3(ii) below.

- 2.(i) This has been acknowledged through the TaMHS Steering Group, which was advised of the research project in December 2007.

- (ii) This seems to suggest that during the period of therapeutic interventions at TaMHS other professionals should not contact parents or children about their therapy. The suggestion in this concern goes beyond research. It is not clear it is practical or reasonable, e.g. a SENCo may wish to discuss with a child their therapy with a view to further referrals.

- 3.(i) Consent is properly sought via the letter to parents. A matter not explicitly raised is that a child's "consent" to an adult may not be true consent because of the explicit power relationship between the two.

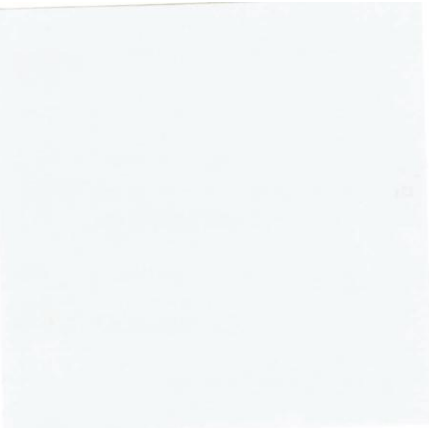
- (ii) This appears to be the crux of the matter, namely the risk that any interview with a child about their therapy, before, during and after intervention could "re-ignite" the issue that gave rise to the need for intervention.

- 4.(i) The purpose of this request is unclear and if acceded to, could affect the objectivity of research.

5. As a general point, it is not clear whether the Codes of the Professional Bodies are intended by them to span the activities of other professionals. If it were, then this would be a very unusual circumstance. In addition to this,

- (i) It is for the trainee and his supervisor to be held account to their own professional body on the adequacy of consent.

- (ii) It is not clear how these breaches occur.
 - (iii) This seems to suggest that the breaches in (ii) above are more of a breach if the child is not told about the Code of Ethics and talked about it with their therapist. It is very difficult to see how the research could remain objective in these circumstances.
 - (iv) This extends the complaint considerably but suggests the Medway Council Ethics Committee is ignoring the breaches in (ii) and (iii) above. "Ignoring" is a positive action as opposed to, say, "ignorant of."
- 6.(i) This has been refused.
- 7.(i) As in 4(i) above, it is not clear how it is rationalised that Onside is responsible for the research and that either Ethics Committees should be paying heed to other Professional Bodies.
- (ii) There is no hard and fast rule to this question. However, the letter to the parent makes clear that if there is any sign of distress, interviewing will terminate.



18 February 2011

Dear Jane,

We are writing in response to your request for a UEL response to the questions being asked about Dr Ricardo Estee-Wale's research in Medway.

Ricardo is on a full time Professional Doctorate in Educational and Child Psychology. He is now in his third and final year. As part of the programme Ricardo has to undertake training in research methodology and complete a piece of doctoral level research.

He has successfully completed his research training which included the development of a research proposal. This research proposal was developed in conjunction with Medway Educational Psychology Service and focussed on "The Construction of Mental Health in Everyday Life and how Children in Medway evaluate TaMHS Therapeutic Interventions". Ricardo submitted an Ethics Proposal to the University Ethics Committee and we were informed that his research was approved on 7th September 2010. Information about the UEL Graduate School ethics committee can be sought from Debbie Dada, Administrative Officer for Research, The Graduate School, University of East London, 4-6 University Way, London E16 2RD, Phone: 020 8223 2976.

It is our understanding that Ricardo also applied for Ethical Approval from Medway Children's Services Ethics committee and that his application was approved.

It was stated in both ethics approvals that the researcher intended to use a semi-structured interview with six children their respective parents, teachers and SENCos. The semi-structured interview questions that were to be used were included as part of the applications for ethical approval.

We have checked with Medway Educational Psychology Service and with Ricardo and it is clear that Ricardo has carried out the research according to the agreed procedures. This includes gaining parental permission and informing the children about the process and asking for their approval to interview them.

As you know the TaMHS steering group were informed about this research on [date].

Once questions about the ethical process were raised Ricardo postponed any further data gathering so that the situation could be clarified with those involved.

In summary we consider that ethical approval has been appropriately sought and the research is proceeding correctly. However there are clearly concerns from some Medway TaHMS practitioners and these need to be carefully considered.

Current Government thinking emphasises the importance of giving children a voice. It could therefore be argued that it would be unethical to halt research. However if Medway Council now believes it would be unhelpful to these children, families or the wider community then you clearly have a right to halt this research.

An alternative way forward might be to review the questions being asked of the children and to agree a new set of prompt questions that would be agreeable to all parties.

Please also note that from the University's perspective it is not essential that Ricardo continues to collect data from children. He could complete his data gathering by now focussing on collecting data from parents and/or teachers.

I hope this letter clarifies the processes followed up until this point. If it would be helpful we would be available to come to meetings in Medway to help find a way forward.

Please do contact us to let us know how we can help further. We hope that this can be resolved as soon as reasonably possible.

Yours sincerely,



Academic and Professional Tutor

Programme Director and Director of Studies

cc.



Notes of meeting to discuss TMHS research

15th March 2011

Present:

Headteacher, Silverbank Park
Psychology and Inclusion Services Manager
On Side project manager
(REW) – trainee Educational Psychologist
– TMHS co-ordinator
– Assistant Principal Educational Psychologist
Senior Educational Psychologist/UEL supervising tutor
Well Being Services Manager (notes)

NM agreed to chair the meeting. It was agreed that MT would set out the processes that REW's had followed. JM added that the meeting was a chance to discuss the concerns raised and to arrive at an agreement over the facts, thereby repairing any problems.

MT outlined the situation, saying that REW's research and data collection had been paused so that checks could be made to ensure that all due processes had been followed. These were:

- The University of East London (UEL) had checked that its own ethics procedure had been followed and had also checked with REW that the work he had undertaken was in line with the approval he had been given.
- UEL checked that the work had been approved by Medway's ethics committee.
- Both UE and Medway agreed that the research was valid and was worthwhile. UEL confirmed that it had met the academic standards the University required.
- Medway had confirmed that it wished the research to continue.
- UEL supported the research.
- Dr Mark Fox had also been consulted – he has wide experience in this arena (MR gave examples of the work Dr Fox has done).

This meeting would allow face-to-face confirmation of the checks that had been made and would help to avoid misunderstandings.

JM agreed that this was a good summary of the situation, and said she was reassured that the processes followed had been satisfactory.

KP said he had not known whether there were indeed ethical concerns over the research which is why he had requested the review. He had not known that the research had passed through ethics committees.

JM confirmed that all research undertaken by Educational Psychologists would undergo similar ethical checks.

HB said she was grateful for the meeting and to hear about the ethical processes. On behalf of TMHS therapists she had some questions regarding the research:

- How would the researcher deal with children whose distress was "reawakened" by the interview process?
- Did the child understand the reason they were being interviewed?
- If a child was distressed how would he or she and their family be supported?
- Was the research only taking place in one particular school? If so, how was this a large enough study?

MT explained that there are various research paradigms and that even small scale studies are valuable as they allow researchers to aggregate data. It is also important to research in depth rather than in breadth as this allows triangulation with other studies. Small samples do not invalidate findings, but they do need to be interpreted with caution.

REW explained that he was carrying out qualitative, rather than quantitative research. He was interested in the children's stories, and narrative research is difficult to do with groups of more than six children. He is the Educational Psychologist for more than one school and the study was not intended to focus on a single setting. He confirmed that he had never personally contacted any child or family direct, and that any such contact was carried out by headteachers or SENCOs.

RB confirmed that REW had not been given children's names before parental consent had been received.

REW covered the issue of a child's potential distress by explaining that all Educational Psychologists are trained to recognise when a child is becoming upset and can deal with it appropriately. This is particularly important in cases of disclosure. If a child ever became upset during an interview the conversation would be terminated.

Appendix 8

Complete Data Set

Parent Interviews

Teaching Staff Interviews

Pupil Interviews

Parent Interview

Parent of J

Ric: Hello...thank you for agreeing to be interviewed by me. This will be a very short interview but whatever you tell me will be very important. Whatever you tell me is confidential. If I choose to use any part of this interview you will not be mentioned in person neither will the name of your child be revealed or the school he attends. Are you happy for the interview to go ahead?

Parent: Thank you I just hope that what I say is important enough to help you with your research.

Ric: Can you think back to the time you thought that something was not quite right with your son?

Parent: I knew that something was wrong with him because he started to behave differently. He'd come in and go straight up to his bedroom. I'd talk to him but he would only give me yes or no answers. I went to the school to tell his teachers about you know like how he has been at home and the sort. At first they must've thought I was going crazy because he was okay at school but afterwards they too found him difficult to handle. It was after that that they told me that some sort of counselling might help him...He had those problems all along but they couldn't see it. I mean they're loads of them in the class. When his teacher realised he had a problem then he got some help for it. It got to the point he had no real friends in the school, he was very lonely. Another problem is that J has got ADHD and many kids don't really understand him...erm I think that adds to his problems as well

Ric: Thank you. Yes you are right, I want to talk to you about the help that your son got through TaMHS which stands for Targeted Mental Health in Schools. Could you tell me the a little bit about the problems your son was having and why he was referred to TaMHS?

Parent: You could say that the problems kind of started at home. Things were quite difficult; me and his dad split up and I think it was quite difficult for him. At first he was having contact with his dad and then it all stopped. It was his dad who won't turn up when he had promised the kids and it was me who was made to look like the bad parent. He felt that I had stopped him from seeing his dad but that was just not true it was all his dad's doing. Our divorce became messy and I think J thought I was punishing his dad by not letting him see the kids. He was quite close to his dad; one day we are all living together as a family, then we split up and then all of a sudden he isn't seeing his dad any more. I think it was all too much of an upheaval for him.

Ric: And is this the main reason why your son was referred to TaMHS?

Parent: Yes, Mrs...contacted me and said that the school might be able to help with the problems he was having; I was all for it really.

Ric: TaMHS is about mental health; did the term mental health concern you at all?

Parent: I've never really thought that my son had mental health problems... perhaps I didn't take too much notice of what TaMHS stands for really. I was more concerned about my son getting the help that he needs... In terms of his problems I think it was the family break up that caused his problems but I wouldn't say he had mental problems, it was more family emotional problems if you get what I mean. I would have accepted any help at the time because I was having problems of me own.

Having to look after all the kids alone and with his dad causing trouble we were all having problems...It wasn't only J but if I'm honest his problems were the worst because he was very close to his dad

Ric: Do you think that TaMHS helped your son cope better?

Parents: A bit...things aren't still great with me and his dad and until all that is sorted he won't be okay totally...but at least he had someone who could help him and that's better than not having any help.

Ric: Thank you very much for answering my questions. Did you find any of my questions difficult to answer?

Parent: No not really; I've had to tell the same story to so many people and Mrs...It's just how things are now, it will all get sorted some way or the other.

Ric: Thank you, once again.

Parent Interview

Parent of G

Ric: Hello...thank you for agreeing to be interviewed by me. This will be a very short interview but whatever you tell me will be very important. Whatever you tell me is confidential. If I choose to use any part of this interview you will not be mentioned in person neither will the name of your child be revealed or the school he attends. Are you happy for the interview to go ahead?

Parent: Thank you, I understand, I am happy to answer your questions

Ric: What has Mrs...told you about my research?

Parent: This is not the first school I have had problems with erm, erm...I don't mean it like that, G has had problems in other schools before so I'm used to talking to the school about the things he gets up to.

Ric: Thank you for telling me that; it's very useful but can you cast your mind back to when the head teacher of your son's current school asked you about the particular problems your son was experiencing and the help that was on offer.

Parent: Yeah, sorry, I know what you mean now; I started talking about other things didn't I? The problems G had in London followed him here from other schools in London. Mrs...asked if I could have a chat with her in her office about my son's behaviour and how the school can help him. First of all I thought she was going to tell me about all the bad things G was getting up to in school but this time she told me about the help she could give him. He has been talking to someone on school

about his problems. I think it is finished now but Mrs ...said that you want to talk to me about it.

Ric: Thank you. Yes you are right, I want to talk to you about the help that your son got through TaMHS which stands for Targeted Mental Health in Schools. Could you tell me the a little bit about the problems your son was having and why he was referred to TaMHS?

Parent: I suppose I have to take some responsibility for what G saw at home. It's not right for children to see their mum and dad quarrelling and fighting. I should've left a long time ago and not make my children go through hell. When we left London and moved to... I didn't know that he would get into so much bother. At the time teachers just thought he was a bad kid but I knew inside that the way he was behaving was because of what he saw at home and his friends he was missing. I know that his behaviour changed because of what he saw and because he had to leave his home and his friends. You can see now that he's back to normal.

Ric: Am I right in saying that it was the domestic situation at home that was quite negative To the extent that it affected his behaviour is school?

Parent: Absolutely, he was so scared of his dad especially when he started shouting at us. I remember that sometimes he used to wet the bed because he was so scared to leave his room and go to the toilet

Ric: What is your understanding of what your son was going through at the time?

Parent: Our social worker at the time said that it was domestic violence...Although the violence was mainly directed at me she said that the children were affected as well. G suffered from it more than his sister because his sister hasn't had the same

problems that G has. G is the oldest and sometimes he wanted to protect me from his dad but he couldn't. He is very sensitive like that.

Ric: So what did you think was happening to him during this time?

Parent: I really think that at the time when all this was happening it really messed his head up. It was too much for a young child to take on and so in school he just became naughty but not only at school, at home he can be a right little devil but I know it is because of the violence he saw at home with his dad.

Ric: What sort of problems does your son have?

Parent: He's not as bad as before because he got some help in school but then I would have said that he had got severe emotional problems.

Ric: What did you think about your son being referred to TaMHS?

Parent: I was so desperate for help I would have agreed to anything at the time. Seriously though, I know that the school has his best interest at heart and that they will always do the best for him and so in a way I did not really question what was going to be done to him.

Ric: TaMHS is about mental health; did the term mental health concern you at all?

Parent: Emotional health, self esteem health and even mental health all mean the same thing; it means that something is going on in your head and in your heart and so help is needed. I suppose though that mental health is more serious than self esteem but what G was going through at the time was serious because it was messing with his head.

Ric: Thank you for your responses to my questions, you have been most helpful. Is there anything that you needed clarified or are there any questions that you did not like me asking?

Parent: No problem...I don't think I can think of a question that I want to ask. I hope that what I have said is useful and I hope that your research goes well.

Ric: Thank you very much!

Teaching Staff Interview

Head Teacher: Robin School

Ric: Hello P

P: Hi

Ric: I'm just going to ask you a few questions in relation to TaMHS, about seven questions in all so please speak as freely as you can. Could you please tell me about your school and the demographics from which most of the pupils come from?

P: We're a very rural school in the Peninsula, a one form entry primary school. Most of our pupils come from the local village, although about 20% of the pupils come from further afield but still from the Peninsula. People here are mostly homeowners most of which at least one parent works. A suppose you could describe us as a bit leafy glade, rural middle class. We only have one family from a different culture.

Ric: So, okay, very mono-cultural

P: Absolutely

Ric: What are the main issues with the families you work with that you are aware of? What has had an impact on their emotional well-being?

P: With our families we've had bereavements, very close bereavements. We've had parents who have died; two mothers have died with very young children at school. We've had split marriages, adoption, looked after children and problems associated with that, for example, neglect. We have had some disclosures of abuse from pupils and that probably about it, if not more.

Ric: Disclosures of abuse from pupils? Were they ever substantiated?

P: Yes

Ric: Right, and so you have had social work involvement in some of these cases?

The adoptions and looked after children are they from other areas?

P: Two cases, one group that were from a different area came to be adopted by M parents and a family of four pupils that were at our school became looked after children, children in need and then some continue to be looked after, after two years.

Ric: I'll be talking to some of these children later this afternoon so if you can take each case individually. What were the observed behaviours within the school, classroom or playground in general?

P: I'm looking at the children you are going to meet.

Ric: Yes

P: B is very anxious. He had maskers in his ears as a very young child.

Ric: What are maskers?

P: Maskers, just to mask out the rest of the world because he has a hearing impairment and he now has got a diagnosis for ASD. B is very anxious and they have a family history of ASD so he would be very anxious. The attachment issues, small things would be very difficult. Changes, we have to prepare him a lot for that. He doesn't make friends well, so there are social issues out on the playground. That's B.

You're going to speak with L. L has ASD and has sensory issues. He's again very anxious. He has kidney problems as well and he's got physical problems. He's

absolutely desperate not to stick out in a crowd, he wants to be totally the same but he knows that he can't have somebody touch or even brush him and they can't make him sleep at home. We don't see a lot of aggression in school because we have I suppose, well, under control and we know how to deal with it. But at home he has what mum thinks as of 'meltdowns'. He's living within a family. He had difficulties at home when there was domestic violence. L and the young children fled the home. They're now in another relationship but with that relationship the mother died. So it's an extended family with quite a lot of emotional difficulties.

So L lives with his mother and her partner, they're not married but there's a relationship, so it looks like a real step family and he calls the dad of the other children 'dad'. So looking at it, it's a fulltime group. He is quite controlling of his own needs. He reflects a lot and he is very hard on himself and wants to be absolutely perfect. That's L, he's quite a complex character. He doesn't stick out a lot because he never allows himself to stick out.

JH, he is in Year 6 he didn't come to us until the beginning of the year. He is very quiet. He's got ADHD. He has individual support from TaMHS. He comes from a very disaffected family. His sister has ASD and he is almost withdrawn. So he almost doesn't get noticed and he doesn't do anything that will bring attention to himself down to his work. He gives the opinion that he's quite capable but underneath he's really not. He needs some support in order to make good progress.

Ric: So I think you've answered my next question. Why were each of these pupils referred to TaMHS specifically? Which area of TaMHS are they in?

P: B has play therapy, L has group drama/art therapy and J has some reflexology.

Ric: Going back to the observed behaviours within the school/classroom, were they ever disruptive? If not what brought them to your attention?

P: Not really, not really disruptive but very needy, quite complex and if that could change...because he's quiet that what makes him stick out. Very polite but very quiet and doesn't give much away so that really worrying because J is moving into a secondary setting so we needed to be able to target resilience. But with B, with his anxieties, not wanting to go out a lunchtime, not wanting to join in with any group work, wanting to work solely individually. And with L I suppose because of his complexity of his needs and he has had a physical programme and the fact that he has attempted self-abuse too. So at home they get a bigger meltdown, we don't get that in school.

Ric: When you say self-abuse, as in self-harm?

P: Yes

Ric: Ok. So would you say that it's the feedback you got from the family that brought him to your attention or without that would he still be someone who stood out?

P: He might have been. He would have stood out because of all that restraint he puts on himself and the pressure he puts on himself. But obviously that's exaggerated by the facts of what he's doing at home and mum obviously brought it to our attention

Ric: Academically, before TaMHS where were they within the curriculum?

P: Both fairly average

Ric: Average?

P: I do have one more pupil who is female but we've had no response from her

Ric: Ok that's fine, thank you. Do you think that schools and teachers are equipped enough to identify mental health difficulties in children?

P: We're not, no. I think we need some support in that. We see the response from them, maybe having mental health difficulties but we don't always identify it as that as we're coming from the curriculum side first, academic side first. Because of our interaction with TaMHS and our part in the project we are probably much more aware now than right at the very beginning. Perhaps you'd like some examples of how we could spot that really, we should look at it from a different angle

Ric: Ok, what has been the progress, if any, of each of the pupils since TaMHS interventions?

P: I think that J is able to voice his responses about himself really, to join in a bit more, to feel a little bit more confident. He also had some 1:1 tuition, something that may well have boosted him academically as well. He is able to ignore, I think some of the things with the classroom dynamics. He joined the class at school at different times. So he's has all of those bits on top of that as well. Obviously, that was a class that gelled together right from day one – reception right the way through. So that's difficult in itself, isn't it?

Ric: What year is he in?

P: He's in Y6 now

P: He didn't come until Y5

Ric: Y5?

P: So he has learned how to deal with that – the dynamics within the classroom a little bit more. B has a much better response within school time and term time and has responded well to a new teacher to this school. So he's able to talk to her a lot more than perhaps he did with his previous teacher

Ric: And what therapy has he had?

P: 1:1 play therapy

Ric: 1;1 Play therapy, yes?

P: During holiday times he is more anxious, so we've begun to almost support him during term time but we now that anxiety really exists. About a week before they ever come back for school he's asking about being prepared. He knows school is in a week's time. So we have sort of stopped it all happening but we've been able to notice it is a bit quicker. He's like that within the classroom and within school. He's able now to probably do a bit more negotiation with some of the pupils out on the playground, as unstructured time, which is most crucial for him

Ric: Nice

P: L. I don't think we have seen a lot of change within school, because he's always in control of himself and at home because of what's happening within the home and school with TaMHS

Ric: So TaMHS actually goes into the home as well?

P: Mum came in to school and worked on 'What ASD Means to Me'. What is ASD, and what does that mean. They worked together for months as a couple of sessions as well with L

Ric: Was that through TaMHS?

P: Yeah

Ric: Right, ok

P: TaMHS led up to that and I think that it made a large difference at home and maybe we've seen that. L is always in self-control, totally in control at all times.

Hopefully, I know they're seeing a little bit of change at home

Ric: Thank you. Do you think that mental health provision should be based within school or outside of school?

P: In an ideal world, we'd have everything in school, wouldn't we? I think we would. Because of all that 'joined up' thing, it doesn't have to happen in school, but it needs to come. We need to know of it. I think it's probably contextually better for it to happen within school. Children don't put their lives in little compartments, do they? So I think we're happy to be able to arrange to have it within that time. Because, if they're not in a place to learn they can't do it can they? I think it just recognises that really, doesn't it though? It can happen in school and that's ok

Ric: I know the school is involved in TaMHS. When the children have therapies, do they go outside of school or does everything happen within school?

P: Everything happens in school

Ric: In school, ok

P: They need to have permission to have it in school

Ric: What about the pupils who don't want to stand out: They're taken out of the class. What effect do you think that has? Taking them out of the class and then coming back into class after therapy, without anything happening in between?

P: We did put things in between. Because one thing that we have noticed that children when they come back in, they needed down time. They need that sit out, quiet space to be. We make provision for that for all of them. But they are not expected to go back straight into the classroom. They can get a drink, go to the toilet, sit down for a few minutes in a safe place and then join in. We don't take children in and out of the classroom lightly but when we do we make sure that it works well and sensitively. And what we ask is that the therapists just make themselves quietly known and quite often the child actually responds and they stand up and leave. And nothing is made of it big in the classroom

R: Thank you very much; and my last question: If TaMHS were to continue, would you refer more pupils and why?

P: Yeah, I suppose. Yes, we would continue to use therapies. We're seeing positive steps, children becoming more resilient in themselves, more able to take control and I think it's good for parents to have knowledge too that actually it isn't about academics, it's about a bit more. They're not learning, they're not making progress, let's try and support the whole child really. We would continue if we could. It's a money thing

Ric: Thank you very much.

Teaching Staff Interview

Head Teacher Hen School

Ric: Good morning, I'm at (Hen School). It is the 7th of April, and I'm speaking to the head teacher, Mrs. C. Thank you for agreeing to see me for about 15-20 minutes. I'm going to ask you some questions regarding TaMHS. So, if you may, could you tell me about your school and the demographics in which most of the pupils come from?

CC: It's a small, rural primary school. Most of the children come from the peninsula, but they come from a variety of villages, including the three... villages. But we also have children from... and quite a large percentage from.. . High mobility. They tend to swap around schools for various reasons. A lot of social housing but, obviously, also big areas of farmland, so there is rural deprivation, which, obviously, I appreciate isn't the same as deprivation. A lot of quite lonely people. Public transport and things is not good. A high percentage of one parent families.

Ric: Thank you. What are the issues within the families that you're aware of which may have an impact on children's general emotional well being?

CC: I think a lot of it is to do with the rural deprivation. I think, especially where you've got one- parent families, they're on handouts, so there's not a lot of money. So, everything is very tight. The children are expected to do a lot of things. There's an awful lot of children that, when you go home - even in the dark in the winter - they'll be out playing. I think it's a quiet life a lot of time. There's nothing to do out here. There is a village hall, there is a small church, but that's it. The school really almost is the hub of the community. So, when we do things, yeah, that's full. But the rest of the time, the children wander. So, we have quite a lot of children with

emotional problems. Quite a lot of children on the child protection register and children in need, considering how small the school is.

Ric: I suppose that's why... was chosen as one of the schools for TaMHS.

CC: Yes, I think so. We have a home school support worker as well, which the school also employs . The reason I employed her was because of that, parents - as you say - splitting up, or one parent families having problems with the rent and this and that. So they'd come to us and say "Help, what can we do?"Which is why we employ a home school support worker who does an awful lot of that work for us.

Ric: So what is your understanding of mental health?

CC: I have to say, my understanding has perhaps gone up a bit having had a member of staff who's had mental health issues. She's been off sick with anxiety and depression. I think coming back on a phased return that opened my eyes a bit more, I'll be very honest. I think probably a large percentage of the population was quite ignorant of that side of things. The emotional side you can see, especially with children. I think it's different with children, because I think children tend to be far more open and far more honest, whereas I think adults tend to put on a front.

So yes, I'm far more up on it than I was.

Ric: I'll have a chat with you, off record!

CC: OK!

Ric: So...school is part of the TaMHS project and so obviously kids will be referred, or used to be referred because it's coming to an end. So what were the observed

behaviours of certain children within the classroom, playground or the school as a whole that sort of highlighted them for TaMHS?

CC: For TaMHS. TaMHS had something called the Vulnerable Children's Register, which we filled in for every child in the school, to be quite honest. When you first look at it, there's millions and millions of boxes, and you think, "Oh, my god." But actually, it covered everything, from additional educational needs through to the emotional side of things, those who are known to social services, all the other external agencies.

Ric: So, had they worked with an educational psychologist? Had they worked with speech and language?

CC: Some of our kids on School Action Plus may have worked with a Speech and Language Therapist and an EP

Ric: Apart from those having contact with outside agencies how were other children with emotional difficulties identified?

CC: You could see, right across each class, who had done things, and who perhaps had in the past. That was a good starting point.

Then we also looked at those children who, perhaps, sat back, were quiet, introverts, and actually, also the extroverts. Also, there were things like family issues that we knew about. For example, the young man we spoke to this morning. We obviously know about those family issues, and the impact that they are having on him.

We looked at all of those things and then said, "Right, we think this child would benefit from that. This child would benefit from that." That was where we went from.

Ric: So the child in question, was it what you knew about the family background, or the behavior of him in school? What was it that made you specifically refer him to TaMHS?

CC: What we knew about his family background and what was happening, because we also knew from something his mum had said. Because obviously, in some ways, he's not the average child in this school because he has got both his parents, he lives in a nice house, etc. He's not your typical child that is referred to TaMHS. But because we knew of his circumstances. Mum had come to us and was very worried because he wasn't talking. He's a very extroverted child. Actually he wasn't talking, because he didn't want to worry his mum. Anything that was worrying him, he wasn't telling anybody. So, we thought it was important that actually has that outlet.

Ric: When I spoke to him, he was talking about the fact that he wasn't able to sleep, because of his brother's difficulties, and waking up at night. Were there other things?

CC: I think he worries if his brother was going back into the hospital and thinks that he might not come home again. It was all the anxiety. He won't talk to his mum. His parent's I think, are brilliant. I take my hat off to them. I really do. They are so open. R knows everything that's going on. But, he also won't talk to them, because he doesn't want to worry them. He doesn't want to upset them. He keeps things inside. Things do come out at school. I mean, he's been in trouble at school - nothing major, silly things.

Ric: And so school and TaMHS is an outlet for him.

CC: Yes. We just felt it would be nice for him to have an outlet.

Ric: Apparently, according to him, he had both reflexology and play therapy.

CC: Yes, that's correct.

Ric: I just thought it was one child, one therapy. I didn't know you could have a menu.

CC: What we did was, we started the reflexology because we thought he would enjoy that. From that, and talking to the lady who was doing the reflexology. Some of the things he said. She actually, also recommended that if there was a play therapist, it would probably be very good for him. To have somebody on a one-to-one, that he could just talk to and know that it didn't matter what he was saying. Obviously, that was done through the play therapy.

Ric: There is something you alluded to in the beginning. You said about how this place is very much a rural place. That the school is at the hub of everything in the community. Now, with Extended Schools, you've got schools who give breakfast to kids. Teach the kids. Then they've got After School Clubs. So in fact, the school becomes the parent. And now, within Extended Schools and SEAL you've got the added influence of Targeted Mental Health in Schools. Do you think that teachers are equipped enough to identify mental health difficulties in children?

CC: I think the simple answer to that, is no. I think you pick some things up almost by chance but we do pick things up especially one of the more experienced members of staff. I do appreciate that teachers are now doing training in mental health. Whether what they are starting to do is the right thing, I don't know. Our current SENCo is very experienced. The trouble is, especially in the primary schools, you are a jack of all trades. We teach all subjects. We cover everything including, all the additional education they need. No, I think probably, because mental health isn't something they talked about. It's interesting to see that suddenly there has started to

be adverts on the television about it, for example. I think yes, it is a hidden thing. No, I don't think we necessarily know enough about other things, as well. Where you prioritize, I don't know. But no, I don't think we know enough.

Ric: Thank you. My last question. If TaMHS were to continue would you refer more people?

CC: Yes, we would definitely use TaMHS, if it could continue. Yes, I would definitely. The annoying thing is, we'd already actually got the next children that TaMHS would be appropriate but it is coming to an end. The lady that's been doing the play therapy is leaving. As you've already said, it isn't always going to continue. I always think it's a shame, these things. I appreciate the funding issue. I'm well aware of that.

Ric: I'm hoping that the model which TaMHS produced can be replicated. Even if it doesn't, TaMHS in itself could be replicated in another form. For instance, secondary schools have got Onside. TaMHS replicated Onside. So TaMHS, in effect is Onside in primary schools. So there is nothing to say that they can't be parallel on-site.

CC: I certainly think it's been a wonderful thing. I mean, the difference in some of the children. R has literally just finished his. Especially the younger children, a couple of them that I can think of. I purposely didn't choose. Because I don't think they would have spoken to you. But the difference the staff and the parents have seen has been phenomenal. Which is absolutely wonderful.

Ric: I did say that was my last question. But something just came up to me. There's TaMHS in school. The child goes out of classes. Does a child remain in school? Does he or she go to another place and then returns after the therapy?

CC: Presently, it's done in school. The reflexology was done in a small, quiet room. The play therapy is done in here, for example. It's private, people aren't allowed to come in, and everybody knows you cannot. Unless it's a fire or an actual emergency nobody can come in here. It's just the therapist and the child. They can talk.

Ric: Is there any after effect? For instance, reflexology you come from a very calm medium into a place that is not as calm. Has there been any difficulty with the interface of finishing therapy and immediately going back into class.

CC: No, I mean obviously all the staff are aware of what is going on. Hopefully, they've got time to sort of, to take a breath and catch up. Yes, there was a problem. We've tried to do it so perhaps they come back in assembly time or a play time. So they have got time to re-adjust. Yes, you are right sometimes that is impossible. We look at the ages of the children, as well. Because, obviously, it's easier for a younger child to go back into the lesson than it is perhaps for an older child. So we look at the timing around that. We usually do it either side of play time and assembly time.

Ric: Thank you very much. I'm sorry that Hen School became the battle place for psychology versus therapists. This marks the end of the interviews.

Teaching Staff Interview

SENCo Sparrow School

Ric: Hello I am with the SENCo of...H. Thank you for agreeing to meet with me so soon. Hopefully this interview will not take too much of your time as I appreciate that you have a very morning today.

H: Every day that I spend in school is busy and not just this morning. I very interested in TaMHS and what you project will write about it. I need to be in class in about 20 minutes time, I hope you can get everything done by then

Ric: Thank you, I suppose I should delve straight into the heart of the matter. Could you tell me about your school and its demographics? Who are the typical children who attend your school?

H: As you may well know we are the poorest area in...and with it comes its own peculiar issues. Many of our children live in homes that are on or just above the poverty line. Many of our parents are unemployed and we have a very high incidence of one parent families. I use the term one parent families very loosely because a more accurate term is single mum families. These mums have partners or ex-partners who do very little in the raising of their children. We have families fleeing from domestic violence and some where domestic violence is very apparent. In our school we have only a very few children who did not live on rough council estates or appalling rented accommodation. In short most of our children are known to Social Services for one thing or the other.

Ric: Why were these students rather than others referred to TaMHS?

H: We have a vulnerable child register which we use to highlight children's emotional and social needs. If there is a change in their behaviour we know there is a lot of things going on outside the school.

Ric: What is your understanding of mental health?

H: I think that it is your ability to function on a day to day basis, it's your ability to function on a day to day level; not feeling over-emotional. It is about being able to cope with most things in your daily life

R: What are the issues within the families that you are aware of which may impact on children's general emotional well-being?

H: A lot of the children feel over-burdened with responsibility, for example, being worried about their mothers who have been subjected to domestic violence which they too have witnessed. I don't think that such children have the resilience to cope with what they have witnessed. Trouble at home soon becomes trouble at school; you can see it in their behaviour. Sometimes it's rudeness to staff or aggression towards their peers. Most of the time we would be within our right to exclude them but where are you going to exclude them to? Back home where the problems started from in the first place? These children can't cope because their parents can't help because they have issues of their own they can't cope with. Such children tend to have low self-esteem and have no strong friendship groups.

Ric: Would you say that these issues have affected them at school?

Definitely, in terms of JD it was her relationship with her peers and she always struggled with her work but would not want help.

G is new to school and so did not have friendship support. He was isolated and was making very little progress in the class. You have to understand his background before you can really appreciate why he struggled so much in class. He had witnessed so much domestic violence at home that his mother had to run away from home with him and seek help from a women's refuge. The feeling of fear and instability must have had a negative hold on him. When he started here he was very unsettled and obviously worried about his mum.

Ric: Our these the reasons why your pupils are referred to TaMHS

H: Yes, but I need to state that other issues occur which make then good candidates for TaMHS. It could be poor self esteem, children being overtly unhappy in school and other emotional behaviours that draw our attention.

Ric: What is your opinion of TaMHS?

H: It's been brilliant! The way they have been able to help the children has made a noticeable difference in them. The only problem we have with TaMHS as you know is its short lifespan. We are coming to the end of the three year pilot and we don't know what will be put in its place if anything, when it ends. Although it is beneficial to the children using it and to the staff for that matter because a settled child does make the learning environment more conducive... it does have some drawbacks. Because we have no spare rooms in our school the children using TaMHS have to go out of school to access it. It takes time out of learning and this affects their education more if they are struggling with the curriculum already.

HR and JDE (therapists) are very good in keeping the school involved; they come to Social Services and Child in Needs meetings which is something of a rarity in... They

are very good at meeting with parents and answering questions about their service. I don't know the extent to which they divulge information to parents because their work is very confidential. The parents are not always proactive in engaging with TaMHS though.

The only part of TaMHS that has not been useful concerns vulnerable children going from primary school to secondary school. The work they did with some children was very hurried and that is not the most conducive way of working with vulnerable children.

Ric: What has been their progress since TaMHS?

H: In JD we have seen a marked improvement in her attitude towards school, friends. She seems happier, she has a better way of coping with things and she now has more of a voice. She now has the emotional intelligence to resolve things affecting her. When her mum went back into hospital she managed the situation better.

G is a lot calmer; he now has a settled friendship group; before he had a difficult relationship with his peers. He still has some anxieties but is now contained better. Rather than just running and bouncing off walls, he just fidgets.

Ric: Who chooses the therapeutic interventions to be offered?

H: HR the play therapist, we've had mostly play therapy, she does the SDQs. Four of our children have had art therapy.

Ric: Do you think mental health services should be based with schools?

H: Yes and no – because it's easier for us if it was based in school and perhaps better for the child if he or she could go off the school site and come back.

Having TaMHS available is fantastic because it's like having a rapid response team. You can wait ages for a CAMHS intervention.

Ric: If TaMHS were to continue would you refer more children?

H: Definitely, I've got a list; it would be a real shame if it were not to continue. I still have more than 60 children who would benefit from TaMHS (the LA) needs a common approach to mental health in schools; we should all be working together – no silos. The primary job of teachers is teaching but for children to learn their emotional and social needs have to be secure. There needs to be more children centres to cope with these needs. We as teachers cannot provide that extra emotional support that they need because first, we do not have the time and second, we do not have the training. Most of our staff after their degrees went on a one year PGCE course. Do you know how much time was devoted to mental health in schools? One lesson if you were lucky! Now I do not object to teachers becoming involved in mental health but they have to be supported with substantial training and a reduced workload because you cannot not teach and care at the same time.

Ric: Thank you for that.

H: Oh, I forgot to add something about G and JD that might be useful for your research...G is living with his mum at the moment. Mum and dad went through a messy divorce. They left London because the home situation was quite violent. It was very stressful for them G still has contact with dad but at the moment it is going through court. When G first arrived he found it difficult to settle. He took on the role of

the class clown perhaps to cover for the fact that his academic attainments were quite poor. This instigated play therapy.

With JD 18 months ago mum and dad split up; amicably at first but then it got messy. Mum has complex mental health issues. In school JD just looked miserable. She was neglected because of her mum's own needs. She would come into school with head lice and was quite smelly because she hardly ever got washed. JD has a sister but she did not appear to be as affected by all this. As a school we tried to meet some of their needs by bring them into the Breakfast Club. As I said earlier she is so much better having had TaMHS but there is a query as to whether she has a slight form of autism because her social skills are still not great

Ric: That you so much for the further information. I suppose that you will know sooner or later has an actual diagnosis. Is there anything else that you would like to add?

H: No, I think that's it really.

Ric: Thank you very much for your time.

H: Don't mention it, it has been my pleasure. I wish you all the best in you thesis and studies.

Ric: Thank you

Pupil Interview

Pupil J, Robin School

Ric: Hello J. My name is Ric. Thank you very much for taking time and agreeing to see me. I'm an educational psychologist. Do you know what an educational psychologist is?

J: Not a clue.

Ric: Have a guess!

J: Don't know.

Ric: Don't know. Well, I work with children who may be having problems at home or in school. Your head teacher told me some time ago that you were having some problems. If it is OK, I would like to ask you some questions, is that OK?

Ric: What are the things you like about school?

J: Well, I like maths, guided reading, and art.

Ric: And art, OK.

J: And also PE.

Ric: PE. Anything else you like about school?

J: I like that you can socialize with your friends and you can make new friends.

Ric: OK. Do you have a lot of friends?

J: Yeah.

Ric: OK. Do you make friends easily?

J: Sometimes.

Ric: What's difficult about making friends sometimes?

J: Finding something that you've got in common with them.

Ric: Yeah. That's true. So those are some of the things you like about school. What are some of the things you don't like about school?

J: I don't like it when I lose golden time when the teacher yells at me. It makes me feel kind of nervous and it kind of puts me off my work.

Ric: Why does the teacher yell at you sometimes?

J: Well, I'm ADHD so sometimes I concentrate on different things.

Ric: So I'm a person, I don't have ADHD. How does ADHD affect you?

J: Some people think it's because I go hyper because I do go hyper sometimes. But mine is that mostly I don't concentrate. At my old school, I wasn't medicated, so when someone did something wrong I got blamed for it because they thought it was me who done it.

Ric: Really? So, now that you're medicated how is it for you now?

J: It's the same, but also quite different.

Ric: Teachers still yell at you if you aren't concentrating?

J: Sometimes.

Ric: What else don't you like about school?

J: I don't like it when I lose golden time, because sometimes I or the whole class loses it. So, it's really annoying when you can get free time out of lessons and you just have to lose some of that free time.

Ric: Yeah. I do understand that. So, what do you think your teacher thinks about you? If I were to ask you teacher, tell me about J, the good things and the bad things, what do you think your teacher will say?

J: I think she'll say that I'm cooperative with other people and that I'm sometimes good at the lessons where I can get about the whole questions in. On the bad side of then, if I don't really understand, I think it was in the parent consultation, that she said sometime, I get stuck on a question like I'm a rabbit in the headlights.

Ric: What does the rabbit in the headlights mean?

J: That I can't think or do anything.

Ric: Kind of frozen?

J: Yeah.

Ric: What else do you think the teacher would think about you?

J: I'm not really sure about anything.

Ric: That's fine. Let's talk about home. What other things you like about home.

J: I've got a sister who is nine. She also likes to play Xbox with me. One of her favorite games is Halo: Reach because you can change gender from male to female.

Ric: You said Halo or Hallow?

J: Halo.

Ric: Isn't that about...

J: Aliens.

Ric: Oh. It's aliens. I thought it was like war and you're fighting.

J: It is war.

Ric: How old are you?

J: 11.

Ric: Is an 11 year old allowed to play Halo?

J: Yeah.

Ric: Are you sure? My nephews I think they're playing Halo three or Halo two and they're only about 14 or 15 and I'm sure it has an 18 certificate.

J: 16.

Ric: 16. OK. So, what's your certificate on yours? Did you get a 16 as well?

J: It's Halo three which is a 15.

Ric: So that's what you like about home, you like playing with your sister on Xbox. Is there anything else you like about home?

J: Well, other than playing with my sister, with power cuts, we just sit around playing cards.

Ric: You get power cuts out here?

J: Yeah.

Ric: Frequently?

J: Not really scheduled power cuts. It just comes. My mum said if someone burps in the power station it the lights go off

Ric: I like that description. The power station is just over there so I'm surprised.

J: Yeah. But there is one near S and S is quite close to us because we live in ...

Ric: OK. Is there anything else you like about home?

J: I like how you can just do your own thing except for like work and stuff.

Ric: So home, it would be right for me to say that you feel relaxed at home.

J: Yeah. Except for when you have to do homework.

Ric: So, homework is not relaxing.

J: No.

Ric: OK. That's what you like about home. What are the things you don't like home?

J: It was last year we had thunder and lightning with the snow. I like the snow but I hate the thunder and lightning noise. I was quite scared. My sister was in bed but when the power cut came, she was screaming very loud. I was in bed. Because she's quite close to me, I can hear her scream, even with my door shut. I don't really like hearing screaming.

Ric: What else don't you like about her?

J: Not much.

Ric: Tell me about mum and dad.

J: My mum and dad are divorced. My dad, he lives somewhere in Dover or maybe he's moved, I can't remember. He's about 39 or so. My mum, she's 37, just about to turn 38.

Ric: Were you around when your parents divorced?

J: I was five.

Ric: You were five. Do you remember anything about it?

J: Just that a lot of screaming and shouting.

Ric: Really? How did that make you feel when they were screaming and shouting?

J: You feel upset.

Ric: Upset. Is there a lot of screaming and shouting now?

J: No, because my dad very rarely calls.

Ric: Right. So that means when he calls... Is there screaming and shouting when he calls?

J: Sometimes.

Ric: Do you see dad?

J: No, not anymore.

Ric: How does that make you feel, not seeing dad?

J: Well, as we used to do it regularly, like every two weeks, Saturday through Sunday or one time on the half time, we have the whole half term with him, and we did do it regularly for about three weeks, and then he just stopped doing it. At first, because his car broke down, and he said it'll be about six months. So then, six months later, I'm getting ready because it was the second week and a Saturday, I

was getting ready to go to him, and then I was waiting half the day and half the night but and he didn't show.

Ric: How did that make you feel?

J: It made me feel really upset.

Ric: Upset. I would be upset, as well. OK. So there were problems at home when you were five?

J: Yeah.

Ric: So, your mum's with someone else now?

J: No.

Ric: Oh, she's not? OK.

J: Well, I think she is.

Ric: OK. I know you've told me what you like about school, what you don't like about school, what you like about home, what you don't like about home, now, when you are having problems at home and at school, how did you feel?

J: I was quite scared because it does affect you in the future.

Ric: What was making you scared?

J: That if you're, like, a bank manager, you have to add up and take away the money, so I'm kind of nervous about that.

Ric: Do you want to become a bank manager?

J: No.

Ric: So, if you're not going to become a bank manager, what's making you nervous?

J: Well, I either want to be a policeman or a games designer, but the games designer has to know loads of things about computers and the policemen has to know pretty much everything.

Ric: Have you heard of TaMHS before?

J: No.

Ric: Because I know that someone comes in and visits reflexology or play therapy or art therapy with you.

J: It was reflexology.

Ric: Do you know why you are told to go and have reflexology?

J: It's kind of gone a blur now.

Ric: It's gone a blur now. When did you have reflexology?

J: Back in year five.

Ric: So, that was last year?

J: Yes.

Ric: So someone comes and says, 'J, go and have reflexology.' Did you ask, 'Why me?'

J: Not really; I just went with it.

Ric: So, for instance, if I went into my bag and I got you some tablets, and I say, 'J, take these tablets,' will you take them?

J: Well, after the reflexology, she said, 'Would you like to do this again?' and I said, 'Yes, I would like to do it again.'

Ric: What did you like about reflexology?

J: That I could get away from my lessons and just relax.

Ric: So, is it right in saying that the lessons are not relaxing?

J: Sometimes. If it's practical group work or whole class work, I can just sit back and relax and actually not answer a question.

Ric: Does answering questions make you nervous?

J: Sometimes.

Ric: Sometimes. What did reflexology make you feel like?

J: It made me feel happy and relaxed.

Ric: Happy and relaxed. Did you like having reflexology?

J: Yes.

Ric: Do you still have it?

J: No.

Ric: So, maybe before reflexology, you were feeling not so relaxed. What do you think about yourself now?

J: Not sure.

Ric: Not sure. Do you feel as relaxed as before?

J: Not really.

Ric: Not really. What would you like to happen?

J: I'd like to have reflexology again.

Ric: Again. Have you spoken to your teacher, your mum, about it? I just know that reflexology, it's about the feet isn't it?

J: Yes.

Ric: I get very ticklish. Were you not ticklish when it was being done to you? You were? But it still relaxed you, do it?

J: Yes.

Ric: OK. Thank you very, very much, J. I've enjoyed speaking to you. When you see your mum, tell your mum, say, 'Mum, I met someone and he's from Durham, and he goes to Newcastle a lot.' Are you going back into class now? OK. Thank you very much, J.

Pupil Interview

Pupil L, Robin School

Ric: It's L isn't it? What's your name?

L: L.

Ric: My name is Ric, and I'm an educational psychologist. Do you know what an educational psychologist is?

L: No.

Ric: Have a guess... Have a guess.

L: Someone who helps people with their education.

Ric: Exactly. I work with children, who sometimes may be having problems at school or at home. Your head teacher told me that some time ago you were having some problems. Is it OK if I ask you some questions about it?

L: Yeah.

Ric: OK. You don't have to answer my questions, and if you feel that you do not want to answer my questions you are free to go. What you tell me will remain private. No one will know about what you have told me. Right. So, tell me about yourself.

L: I'm nine years old.

Ric: Nine years old?

L: Nearly 10. I've got quite a lot of friends.

Ric: Right.

L: I like to play on my PlayStation.

Ric: Everybody likes PlayStation. Yeah? Is a PlayStation the same as an Xbox?

L: Yeah.

Ric: OK, right.

L: And I like my Xbox.

Ric: Are they two different things, the Xbox and the PlayStation?

L: Yeah.

Ric: They are two different things. OK. What's the difference between Xbox and PlayStation.

L: The Xbox is white and the PlayStation basically is black. The PlayStation is online and it is free.

Ric: Oh right.

L: You can go on the Internet and do Internet searches. Basically, a PlayStation 3 is like a laptop.

Ric: Right.

L: There is an improved version where you get a controller.

Ric: When you play on the Internet, are you playing other people around the world?

L: Yeah.

Ric: All right. What's the furthest away you've played with a person? What's the furthest country?

L: Probably Australia.

Ric: Australia? You can't get further than Australia. If you doing that at night, it would be morning time there, and so...

L: Yeah.

Ric: Oh, right.

L: I also like Prost motorbikes and all that.

Ric: Oh right.

L: I love cars.

Ric: Do you have one of those little cars you ride over dunes? What do you call them?

L: Quad bikes.

Ric: So you've got a Quad bike?

L: Yeah, I've got a Quad. I did have a motor cross bike but we sold that. My uncle's got a Quad as well.

Ric: Do you wear a helmet when you are riding it?

L: Yeah. I've got the full kit.

Ric: So what do you need when you're quad biking?

L: A helmet, gloves, special covered boots that have got metal on the toes, so when you go around you are locked in.

Ric: So when you go around, your foot's on the ground is it?

L: Yeah. Like, you actually put it down sometimes. That's only if you really have a small time Quad, so, like my sister's when I went on it I would have to hold the metal frame on my arm locking it. I was lucky I had my body armor on. When I went around the corner, It just went zoom and I fell off.

Ric: Wow. But you were on dirt tracks weren't you?

L: Yeah.

Ric: OK. So it doesn't really hurt if you fall?

L: No. I've gone in my mum's back garden.

Ric: She must have a fantastically big back garden, then.

L: It's about (gesticulates with his hands) this big it's quite long. It's about 10 meters wide and 15 in length.

Ric: Wow.

L... and a circle with a rosebush in the middle of the track.

Ric: If you fall into her rosebushes, she's not going to be very happy about it. Have you fallen on the rose bushes before?

L: No.

Ric: When I was little and attending a nursery I had this little tricycle. I was going around this rose bush, and it was like, a formula one track. You know?

L: Yeah.

Ric: It had steep curves, and I fell into it and got all these nettles, all these thorns in me.

L: That would have to hurt.

Ric: It hurt, but I don't remember crying. But I don't remember going around a rose bush again!

L: Certainly.

Ric: OK. So L, you've told me about yourself. Thank you very much. Now tell me, what are the things that you like about school?

L: Uh...I like history, because we get to learn about the ancients Greeks and Romans and it's really exciting. So it's like 'Why can't we learn more?' I don't mind science. It's not my greatest in subjects, but I'm it's okay. One of my favourite subjects is DT, because I like technology. I like doing ICT and getting to work on regular computers. I like doing a lot of things.

Ric: What else do you like about school? Not just subjects, what else do you think?

L: I like playtime.

Ric: Right.

L: And lunch time.

Ric: Have you had your lunch?

L: Yeah.

Ric: Like what did you have?

L: I got a lot of things. I like animal biscuits, then my chocolate bar, Sandwiches

Ric: Were these school dinners, or was this a pack lunch?

L: No. Pack lunch.

Ric: Pack lunch, right. OK.

L: I've learned lot of things...

Ric: So, you like your history. You like your DT. You like your ICT. So a bit of science at times. Then you like lunch times and you like play times.

L: Yes.

Ric: Now tell me, what don't you like about school?

L: Usually writing, it tires me sometimes. Or is it one thing, a really noisy classroom.

Ric: So it's noise, you don't like noise.

L: Not loads of noise.

Ric: Loads. OK.

L: It gives me headache. I don't like it when teachers talk for ages. It bores me.

Ric: If she's teaching history, she's going to have to talk for ages, isn't she?

L: Oh yes, I don't mind it for history.

Ric: Right, OK. So what else don't you like about the school?

L: Assembly. You have to sit for about 15 minutes just listening to someone talk.

Ric: Right. So what I can gather, you don't like people who talk, and talk, and talk.

L: [laughs] Not for ages!

Ric: OK, not for ages, then. Are you able to watch films, then? You can watch films?

L: Yeah, I can watch films, because there's action in them. But teachers talking, they just stand still and go.

Ric: And then this is [imitating nonsense] .

L: [laughs] Yeah.

Ric: What does your teacher think about you?

L: Well, I actually don't know.

Ric: What do you think, because I don't know your teacher? If I were to ask your teacher, what do you think she would say?

L: She probably thinks I'm a good kid. I don't really get up to mischief. I'm not cheeky. I can be a little bit cheeky, sometimes. Don't know; can't actually think what she thinks about me.

Ric: OK. So, one thing I know is that what you don't like is talking, and talking, and talking. I know what you like about school and what you don't like about school. OK. Let's change subject. What are the things you like about home?

L: Home, I like my place where I live. I like playing on my PlayStation. I like playing in the garden, I like going out with my friends. I like going on my Quad. What else? There's loads at home. I like watching TV, like my laptop whiteboard, like my i-phone, just listening to music...I like going to bed. I like being in my pyjamas

Ric: Really. Is that on the weekend, or as soon as you get home from school?

L: Usually just on the weekend. If I'm not going anywhere I'll just sit in my pyjamas. I've got loads of things at home. I like playing with my dog.

Ric: What kind of dog do you got?

L: A Jack Russell crossed with a Yorkie.

Ric: Right. Is that all the yapping and yapping and yapping?

L: Yeah. [imitating a dog yapping] . That's about it.

Ric: OK. Now, tell me the things you don't like about home.

L: Oh...my step-brother and sister, being told off or told off for something I didn't do. Couple things...I can't remember anymore.

Ric: OK, you said you've got step-brothers and sisters.

L: No, I've got a step-brother and a real sister.

Ric: Oh a step-brother and a real sister? Tell me about Mum and Dad.

L: Yeah, mum and dad are all right.

Ric: So...

L: I've got a step-dad where I live.

Ric: All right. You live with your step-dad and mother?

L: No, yeah. My step-dad and my real mum.

Ric: Your step-dad and real mum? Do you know why your mum and dad are not together?

L: They had an argument.

Ric: Just one argument?

L: No, they've had loads.

Ric: OK.

L: Then they got back together and split up, got back together then split up.

Ric: Were you aware of that when this was happening, when they were having arguments?

L: Yeah.

Ric: How did this make you feel when they were arguing?

L: A bit upset.

Ric: What is upset to L? Explain what makes L upset?

L: Upset, probably angry... making a lot of racket.

Ric: Just making a lot of racket? So you'd like to make them stop, or what do you do?

L: Usually I just shout a lot.

Ric: Right.

L: And that usually stops them. That did stop them once!

Ric: But it didn't stop them from the other arguments?

L: No.

Ric: Were you, were you ever scared when they were arguing?

L: Sometimes.

Ric: Right.

L: Not usually.

Ric: Right. What happened when you were scared? What were they doing when you were scared?

L: Usually shouting at each other.

Ric: Shouting at each other, yeah. And again, it's talking, talking, talking. You don't like all this talking, talking, talking, do you?

L: No.

Ric: OK. So would you say that those were the problems you were having at home when mum and dad were shouting?

L: Probably.

Ric: Now...

L: The main problem I'm having now is my stepbrother C and my sister, they keep winding me up.

Ric: OK. How do they wind you up?

L: My step-brother just eggs me on, like, 'Oh, come on I'm stronger than you.'

Ric: Is he older than you?

L: No, younger. So he acts really cocky. He's like 'Oh, okay I'm stronger than you' . And I was like, 'C, be quiet or you'll get it.' And then he goes on and on, 'Yeah right, I'm just going to beat you up in a minute.' He tries to jump on my back and pull me around. I'm just like standing up in front saying, 'C, get off my back.'

Ric: Then what about your sister?

L: She usually just smacks me and throws things around in my room and I'm like, 'Put it away.' She says no.

Ric: Is she older than you?

L: No, younger.

Ric: She's younger?

L: I'm the oldest.

Ric: Oh right

Ric: So, I know a lot about you and I know that you are having some problems at home and right now. So when you are having problems at home and in school, how did you feel?

L: Usually, bored as hell or upset.

Ric: Upset. When is L upset?

L: Or usually, sometimes be angry.

Ric: So when you're upset and angry, what do you do?

L: If they wind me up to a certain point, I will lash out back. That's only if they wind me up real bad. But I'm not like that at school, it's at home really, my step-brother does, he eggs me on so much I'm like, ' [screams] .' Sometimes I feel I just want to throw him down the stairs and kill him.

Ric: Yeah. But you've never killed anyone before, have you?

L: No.

Ric: Someone was working with you when you had these problems. What work did you do with this person?

L: I don't actually remember.

Ric: I know you were taken out of class to meet somebody. What were you doing with this person?

L: Oh yeah, was it Doctor P?

Ric: No that's the pediatrician.

L: Yeah.

Ric: Were you not doing play therapy or art therapy?

L: Oh yeah.

Ric: What were you doing?

L: I was doing feet massages.

Ric: Feet massages.

L: Yeah.

Ric: Aren't you ticklish?

L: No.

Ric: All right.

L: I am, but it was so nice I never used to find it ticklish.

Ric: All right. Explain it, what do they do to you?

L: Usually I just got a free foot message, nice cream that smells really relaxing. I nearly fell asleep one time.

Ric: Nice.

L: I was like, 'Ah.'

Ric: Would you say that the reason why you went for reflexology was to calm you down a bit?

L: Probably.

Ric: OK. Tell me, what did he do with you again?

L: Used their hands and just rubbed me on the feet. They put this cream on their hands and they'd do it and it's nice and soothing.

Ric: How did you feel when you had to go back into the class?

L: Still relaxed.

Ric: Right. OK. Do you still have it done now?

L: No.

Ric: No.

L: I had it done about six weeks, I think.

Ric: All right. OK. What do you think about yourself now?

L: Yeah. I think it's improved me.

Ric: What area has it improved?

L: Although I think I am a lot calmer at home, I still lash back because they wind me up to a certain level. That will never improve.

Ric: Really?

L: Yeah, I think so.

Ric: Not even reflexology?

L: No.

Ric: OK.

L: I might be going to ... Secondary School. So my mum was saying maybe if I don't do my homework they put me in a boxing club. I might know that that's the place to do your fighting and not at home. So I might be going to boxing.

Ric: Fight club? Okay. One thing is that you fighting at home is a bit of a problem then?

L: Yeah because they wind me up so and I'm like, 'Aah.'

Ric: OK.

L: I snapped all the guitars I made.

Ric: Sorry?

L: I snapped all the guitars I made.

Ric: You snapped a guitar.

L: Yeah, it was wood. It was one of them I made. It was flat; about this big.

Ric: It must be more than winding you up that makes you lose your rag. What else makes you lose your rag?

L: It's mainly winding me up or it may be because they've nick something of mine. Once my step-brother nicked my boxing gloves. I went ballistic. I wouldn't leave the house until we found them. My mum went, 'Oh, it would be very frustrating if I just nicked them.' I went in his room and I said, 'Get your drawer out.' See it's here, and I knew he had nicked them. So the next thing I saw, he just nicked some money off me as well!

Ric: Really?

L: Yeah he nicks a lot of things, and when I'm older, I'll send him to prison.

Ric: You live with your mum, and your step-dad.

L: Yeah, and my dad lives with his dad, but he's moving in with his girlfriend.

Ric: Right. What's your relationship with your dad like?

L: My real dad?

Ric: Yeah.

L: Yeah, quite good.

Ric: What about with your step-dad?

L: Sometimes he really annoys me.

Ric: Why? How does he annoy you?

L: It's just that if it is C that needs to get told off, he'll tell me off as well. Let me see. I'm trying to think of an example. OK. One time, he goes down to ask for something, and so do I. I just got back and he starts asking me if I did something wrong. Like he would just go on. He'll go, 'Oh, you need to clear up after yourself.' Like say he'd spill a drink, he'll go, 'You've spilled a drink.' And my step-dad will just go into one, when it was actually him that spilled the drink. And my step-dad will just go into one because he thinks it's me. Without no proof.

Ric: OK. Well I finished with my questions. Anything you want to ask me?

L: How many children have you worked with?

Ric: I can't count them all!.

L: Could be thousands.

Ric: Yeah, out to about a thousand, because I used to be a social worker before. I've been a social worker for a long time, then I became a psychologist.

L: Yeah. I had a social worker who worked with me. You might have known her, she's a new one.

Ric: OK. Why do you have a social worker?

L: I think it's because my uncle, I don't know. I think it's because my uncle's helped me and has helped mum with things were bad.

Ric: I don't think you would have been given a social worker for that.

L: Right. It might have been something else. I think she was like a social worker.

Ric: Because a social worker won't work with you because you're angry. A social worker will work with you because there has been some harm being done to you. Someone hit you or something like that?

Ric: Why is the social worker not working with your parents?

L: It might not have been a social worker. It might have been someone else.

Ric: OK.

L: Can't remember her name, can't say.

Ric: Well I don't work with any social worker in M. I work with educational psychologists.

L: All right.

Ric: So you know, it was when I used to work in the north east of England that I was a social worker. Thank you very much. I've enjoyed talking to you.

L: Thanks.

Ric: What I'm going to do is just write these things up out and see what other people have said about reflexology.

L: Yeah.

Ric: You know they quietly kind of enjoy it.

L: Yeah.

Ric: So, yeah. OK. Thank you very much. OK then, see you.

L: Bye.

Ric: Bye.

Pupil Interview

Pupil B, Robin School

Ric: Hello B, my name is Ric. Thank you very much for taking time and agreeing to see me. I am an educational psychologist. Do you know what an educational psychologist does?

B: No.

Ric: Let's move you up a bit. So, do you want to tell me your name? How old you are and what year you're in?

B: I'm in year four. I'm eight years old, nearly nine, because my birthday's on the 25th of April 2002. My name is B.

Ric: Do you have brothers and sisters?

B: No.

Ric: You're the only child?

B: What did you say?

Ric: I said, do you have any brothers and sisters?

B: No.

Ric: You don't have any? So, it's just you then?

B: I kind of like, have like have like a cousin who is quite close to me, but not really my brother or sister.

Ric: Like your brother or sister.

B: But I see him quite a lot.

Ric: OK. We are going to start talking about school now. What other things you like about school, and what are the things that you do not like about school? Let's do what you like about school first.

B: I enjoy literacy, because I like to write stories and do stuff about imaginary settings.

Ric: OK.

B: So that is pretty good. I like playtime. It makes me a bit happy and relaxed and I get a bit of time off doing work at school.

Ric: Why, what do you do during playtime?

B: I like to play. You can see out the window all the space in field.

Ric: Yeah.

B: I might play there sometimes, I do not think so but some children play with hula hoops and skipping ropes... you can have them and you can like play with them and all that.

Ric: OK I'm going to ask you something different now. And what don't you like about school?

B: Maybe sometimes I might have a bad day at school maybe. Like for example, maybe probably falling out with a friend or something?

Ric: OK. What causes you to fall out with friends, or friends to fall out with you?

B: Maybe if there might be an argument or something. Or maybe about, I don't know literacy or something.

Ric: Right. OK. What do you think your teacher thinks about you?

B: OK.

Ric: Mm-hm.

B: Sometimes, mostly she will just come back at lunchtime to do their work.

Ric: Right.

B: If sometimes I have not done enough work. I do not do that really often, because I try my hardest.

Ric: So if I was to ask your teacher, 'Tell me about B.' What do you think your teacher will say?

B: I am not sure.

Ric: You are not sure, OK. I'm going to ask you a different question and it's not about school, it's about home. What are the things that you like about home?

B: What I like about home is, well it's a bit enjoyable for me if you have got a quiz at the end of the school today.

Ric: Is that home or in school?

B: School.

Ric: School, so tell me what you like about home.

B: Home, do you know when you've been really bored at school and you have had a bad day and need to get home a lot. Soon, the day is over at school and you really look forward to going home.

Ric: Yeah.

B: And, also I get some time to spend playing and spending time with my dogs, computer, and other things as well.

Ric: OK. Anything else you like about home?

B: Maybe after the school day, we have some fun stuff happening like, sometimes my cousins come over to see me maybe in the summer after school stops in summer and we play and go to places like the seaside which is not far from here.

Ric: OK. Thank you.

B: That's all.

Ric: What other things you do not like about home?

B: Don't really know. I am not really sure.

Ric: Oh, sure. OK. I know that sometimes you go out of the class with someone and have play therapy. What do you do in play therapy that you do? What do you do?

B: Art therapy.

Ric: Art therapy! OK.

B: It was just like quiet sitting in the art studio.

Ric: In the art studio?

B: Talking to someone and also making things. And I add it to my green folder. And fold it. I'm not really told to draw anything I just draw about something we have talked about, anything really. Drawing pictures and other things as well.

Ric: So do you know why you were having art therapy?

B: No. No I did not really know.

Ric: So someone comes in, brings you out of class and just works with you.

B: It used to be every Tuesday.

Ric: Yeah.

B: Just after playtime there is a therapy worker waiting at the door for me. And then she will just say to the teacher, 'I am just going to take B with us.' She will take me to the art studio.

Ric: Why? Why B?

B: I do not know, but she does take my school friend D as well now. She used to...

Ric: OK, so you do not know why you were doing art therapy? Try and have a guess.

B: To make me feel a bit calmer and better maybe, I don't know.

Ric: OK. That is a good point. So are there times when you are not calm?

B: Mm.

Ric: Give me an example.

B: Sometimes I get a bit angry and I will get a bit too angry and I start getting upset.

Ric: Really? Give me an example.

B: Mm.

Ric: Oh, does B get angry and upset. What makes B angry or upset?

B: Maybe if I was blamed for something or something like that. Because sometimes people get blamed in the school, not much, I don't really hear about it that much. But some time ago when I was a bit littler I used to get blamed for all kind of things.

Ric: Blamed for what?

B: I couldn't remember.

Ric: Oh, OK.

B: It's kind of like, for example, being blamed for something, or so I might get angry with someone, but, you know, they might have said that it was me or my school friend and I might have felt a bit angry about it.

Ric: Right. When B's angry...describe B being angry.

B: If I was angry, I wouldn't really listen to people, because I would be bit too angry sometimes and I wouldn't really want to tell them anything.

Ric: So when you're angry, not listening to people, are you breaking stuff? Are you shouting? Are you doing somersaults?

B: No.

Ric: What are you doing, when B is angry?

B: I don't really do anything like that. Because a long time ago, in year two, I had this boy called...I didn't like him and he left our school because he came in year two,

and he left in year two. He was a very nasty boy, because when he got really angry he had to go into the hall because he was throwing books everywhere, he was throwing chairs at the walls, and there was dirt on the walls because the chairs had been on the floor and all that. Because people have muddy shoes sometimes and they walk on the floor, and sometimes when they chuck chairs in it might get a bit dirty.

Ric: Right. So you were not like him, were you?

B: Not at all.

Ric: So when B's angry, how does B behave?

B: Might be a bit sad and wouldn't really talk to any of my school friends, because I feel sometimes a bit angry so I wouldn't really be interested to talk to anyone.

Ric: Thank you. So, do you now understand when you're having these problems?

B: Sometimes I have a bit of anxiety when I get home. I'm just too upset, but I have no idea.

Ric: You have no idea why you're upset?

B: Yeah.

Ric: OK, now if you can think back to B being upset, what were the problems you were having at home when you were upset?

B: I probably might have been angry but I can't really remember but I'll try. I think I might have maybe gone to somewhere a bit quiet in the house so I couldn't listen to anyone and I could just relax myself. But I wouldn't really go to my room, I'd just go somewhere quiet in the house, maybe.

Ric: Would you talk to anyone?

B: I'll talk to my mum, because my mum works at this school.

Ric: Is she working here today?

B: Yeah.

Ric: OK.

B: She works every day unless she's poorly or something. She's an LSA.

Ric: Oh right. What's your mum's name?

B: H.

Ric: H, I haven't met H before. OK. So when you are having problems you go home and you won't really talk to anybody?

B: Yeah. I would talk to my mum maybe, or my dad because, I mean, like, I think of what my parents tell me that when you don't tell anyone it might not get solved and I just want it to get solved. So that's why I tell someone, but maybe at home, maybe the teacher, but not really my school friends because I don't think they're much of a help at school.

Ric: OK. You mentioned a very good point, that, you know, you tell someone so someone can help you sort things out. What problems were they sorting out for you? Your mum and dad, what problems were they sorting out for you?

B: Maybe anxiety, because I've been with anxiety for quite a long time.

Ric: Really?

B: Yeah, and also I was thinking of other things like, I had other things that worries, because unfortunately one of my school friends at this school died.

Ric: Really?

B: Yeah, he got run over by a car, not a car. It was a lorry. And everyone in the class was crying about it and we didn't really talk to anyone because we were so upset about what happens to B J.

Ric: When did this happen?

B: I think it was 2008 and when that happened I had worries about if I was going to die and parents and all that. My parents took me to see a doctor because of the way I was feeling, not far from where we live I think. And we had to speak to him, this was quite a long time ago, I think it was the same year or maybe 2009, or 2008. And we

talked about it and the doctor said that...I can't actually remember because my mum had... had to sort it out, but they didn't really work that much. So we had to go to the doctors.

Ric: Really? So, do you feel anxious about dying?

B: Hmm.

Ric: How does B feel about it?

B: I still worry about it, just like slightly because I mean, some people worry when they get a bit old. So, no one knows what it's like.

Ric: Yes.

B: I mean, someone can't just come down from heaven and tell you what's going to happen.

Ric: That's true.

B: And how it feels.

Ric: Yeah. I didn't know you'd had that happen to you. What was his name?

B: B J.

Ric: Was he your friend?

B: Yeah, a very big friend. He was quite a nice boy. He was polite, but, as you know, everyone gets told off at least once.

Ric: Yeah.

B: I mean, everyone gets told off at least once, it's like everyone in the world. I mean, you got told off, but you're still a nice boy. He was nice. He was helping other people. He was a very nice boy.

Ric: OK. Thank you for sharing that with me. So let's go back to your art therapy. Did you enjoy doing art therapy?

B: Yeah, because, well the thing I enjoy about it is when I come back into the classroom, do you know what it's like being somewhere really quiet and you come back somewhere and it's really noisy and it's been quiet and it doesn't feel nice because I've been quiet somewhere and it's gotten loud again and it's a bit annoying. In my classroom we had this thing called the kid's corner and we had this box called the feely fingers box and the teacher said to me every day whenever I did every Tuesday they said to me you could tell people... no, it was like she said you could go in there because it's got these Rubik's cubes. It's got toys and stuff like that in it. It was still loud but it cheered some people up. Like, if I'd been sad or ...I mean if you've happy and you've been fine, there's not really a point to go in there. Just like if you've been sad and angry or something.

At the moment, I'm doing this other thing on Tuesday, when that art therapy thing came to an end. Besides coloring this circle each time and when it was all colored in, it would be over. At the moment, I've got this thing, have you heard of me having this social skills group?

Ric: I know of social skills, but I didn't know you were having social skills. So after art therapy the social skills group happens, does it?

B: Not straight away. A couple of months after that. I think that was last year. And social skills is this year.

Ric: OK. And how do you feel about that?

B: OK. It's still noisy when I go back in but, it depends on what the class is doing for the day when you come back in because it might have something that might be like talking to someone and at the end we get this little snack thing and we get to talk to these people and we get to invite friends, just one friend from our class or maybe a different class if you like, and then you have a snack and that's when it comes to the end and that's next, yeah next week.

Ric: OK. Did you like having art therapy?

B: Yeah. But this social skills is about making friends with people, it's got two children from my class and two children from another class and that's it.

Ric: OK. What do you feel about yourself now?

B: OK. I feel good. But in that social skills thing again, you get two people. I'm very glad my aunt runs it and there's another teacher who runs it with her and that's what they do. There's seven, I mean five children, I think.

Ric: So which one did you prefer? Did you prefer the art therapy or the social skills?

B: I'm not really sure, really. I mean they're both good. They're both great. I think social skills is about an hour. I think it was about the same amount of time for the art therapy.

Ric: Thank you very much . I've really enjoyed talking to you. You've given me a lot of good information. What I'm going to do is I'm going to write up what you've told me. I won't put your name there. When I talk about art therapy, I won't say that this is what people talked about in art therapy but that it's something that you enjoyed and what you liked about the art therapy was that it was quiet and you could do things by yourself. Or you didn't like going back to class when it was a bit noisy and things like that. So you liked the peace and quiet of art therapy.

B: Yeah.

Ric: OK. Is there anything else you'd like to add?

B: Just one more thing. Because of these things on my ears, when I was a baby, on my birthday, it was really loud and I think I went off screaming and went into a room and it was quiet I think. I heard my mum talk about it in the hospital to a woman, a doctor, a doctor or a nurse. She said something about me screaming when I was a baby or something. Then, I don't do that anymore now because screaming hasn't been my thing much.

Ric: Thank you very much. Thank you B

Pupil Interview

Pupil (G), Sparrow School

Ric: Hello G, thank you for agreeing to have a little chat with me. My name is Ric, I am an educational psychologist. Do you know what an educational psychologist is?

G: Erm, erm are you like a social worker or something? I used to have a social worker when I was in London

Ric: Yeah, I am a bit like a social worker because I work with children like you but my job is a bit different. I normally work with children who are having problems in school. I suppose I work more with children in school and social workers work more with children in the home. Before I go on to ask you anymore questions I need to tell you that you do not have to answer any of my questions and if at any time you wish to leave this room and return to the classroom please do so. You will not be in trouble with your teacher, or your mum or me. Do you understand what I mean by this?

G: Yeah I do. I'm alright because I'm used to talking to social workers and my teacher

Ric: Thank you G. Now I'm going to ask you about your family. Can you describe your family to me?

G: Well my mum and dad and my sister and me all used to live together in London but we don't any more, me and my mum now live in S.

Ric: Does your dad still live in London.

G: I think he does but I don't see him a lot anymore.

Ric: Do you know why you had to leave London and live in S?

G: Yes

Ric: Would you like to tell me the reasons or would you rather not?

G: I can tell you, I don't mind because I've told other people before. Mrs H knows about it as well.

Ric: Okay then, tell me when you are ready.

G: I think my problems started when me and my mum and my sister had to run away from home because of our dad. It wasn't very nice when we lived with our dad because he kept hitting and shouting at mum. One day when he wasn't in she packed some of our stuff and went to live in a refuge... I didn't like this school when I first came here. I missed my old school and started to get into fights. I didn't have friends and I hated being here. I wouldn't do what the teachers told me to so I had to sit outside Mrs H's office. I think I better now I don't get into so much trouble anymore.

Ric: Thank you for telling me that. You said that you didn't like school; why didn't you like school.

G: Well at my old school I knew everyone and I had some really good friends. When I got to this school I found it hard because I had missed a lot of time because in the refuge I was not going to school. When I came to this school I found the lessons hard and people made fun of me. In the class they kept calling me 'thicko' so I started to get into fights.

Ric: Do you still find lessons hard:

G: Yeah, sometimes.

Ric: What subjects don't you like or find hard?

G: Maths and English but Miss K sits by me and helps me out sometimes and sometimes we sit on a small table together and Miss K teaches us the stuff we don't know or we aren't good at.

Ric: So what do you feel about school now with all the help you are getting?

G: It feels better and because I know more people now.

Ric: Do you have friends now?

G: Yeah, there's J and M and C, they are my really good friends but I have other friends as well.

Ric: Apart from having new friends what else has made you like school?

G: Erm, the teachers I suppose because I can go and talk to them if things are not alright

Ric: Is there anything else that has made you like school more?

G: Erm, I don't think so.

Ric: Mrs H told me that when you were having problems in school you used to go and talk to someone who did some activities together.

G: Oh yeah, I remember; it was a lady called 'H' we used to do play therapy together. I used to like having play therapy.

Ric: Don't you have it anymore?

G: No it finished

Ric: Would you like to tell me why you liked it?

G: I liked going for play therapy because I was able to tell her things that I couldn't tell my mum. It gave me space to think.

Ric: What do you mean by space to think?

G: Well there were some times when I couldn't really talk to my mum about things because she used to get upset about what dad did to us. I didn't have my dad's number so I couldn't talk to him as well. With 'H' I could tell her what was bothering me.

Ric: Is there anything else you would like to say about H or play therapy? How did you feel after play therapy?

G: We used to play with stuff and make stuff. I wasn't told what to do like in class but when I was making things I was able to tell H about what was bothering me.

Ric: What was bothering you at the time?

G: I think it was stuff like fighting and quarrelling all the time and not having friends.

Ric: Anything else?

G: Yeah, before I was worried that dad will come back and so we would have to run away again. I don't feel like that anymore more.

Ric: Why not?

G: I don't know. I just feel happier in school and I know that we don't have to run away anymore.

Ric: Well G, Thank you very much for your time. Are you okay about the questions I asked you?

G: Yeah, I'm alright. I used to have to talk to my social worker all the time about stuff. Mrs H knows about the things I have told her as well.

Ric: Is there anything else you would like to say about play therapy/

G: Err...yeah, I really liked it because it was only me and 'H', I liked doing stuff with her because I was never really told to do anything. I could draw or make things up and pretend it was the school or my house.

Ric: Thank you for that G, is there anything else you would like to say?

G: No not really.

Ric: Well thank you very much for your time. Are you able to go back to the classroom by yourself?

G: Yeah, I know the way.

Ric: Thank you and good bye.

G: Bye!

Pupil Interview

Pupil (JD), Sparrow School

Ric: Hello JD my name is Ric, I'm an Educational Psychologist, do you know what an Educational Psychologist does?

JD: No, No I don't

Ric: Well I help children who are having problems in school, for example, if you are having problems with reading, an Educational Psychologist might come and help you. This time though I am going to ask you some questions about some of the problems you may have had, You don't have to answer my questions and you can leave this room at any time. Would you like to tell me your name and anything else about you?

JD: My name is JD, I am 10 and I was born in March 2000. I have a sister who is 6 years old; she is in Year 2 and goes to the same school as me. I live in R with my mummy and my sister. I have two cats; one ginger and one black.

Ric: Thank you very much for telling me that JD; is there anything else that you would like to tell me about your family?

JD: Well...well I have a mum and a sister, we share the same room, me and my sister...I

Ric: Do you have a dad as well?

JD: Well yes but he doesn't live with us anymore, he lives in G.

Ric: Your dad not being around anymore, how does that make you feel?

JD: Err, I don't know, he used to live with us but not anymore?

Ric: Okay would you like to tell me more about your home? Would you like to tell me about the things that sometimes bothers you at home and also the things that you like about home?

JD: When we first got our cat he kept going under the washing machine so we had to move the washing machine because she kept getting stuck.

Ric: What happened afterwards?

JD: First my sister lied to me that she didn't chuck my book on the floor.

Ric: Okay, I'm not sure if you understood my question or maybe I was not clear enough. Do you think you will be able to tell me some things about your dad?

JD: Err, err I think so?

Ric: Remember that you do not have to answer any of my questions if you do not want to; it's fine with me. Can you remember when your dad used to live with all of you in the same house?

JD: Yes

Ric: What were the nice things you used to do as a family?

JD: Well mum and dad used to take us out; dad had a car and would take us to the beach in G. Sometimes it was cold but he still used to buy us ice cream even when mum said it was too cold.

Ric: Did you want to have ice cream when it was cold?

JD: Yeah! We love it.

Ric: You said that your dad doesn't live with you anymore; where does he live

JD: Dad lives in G. I don't know why he doesn't live with us anymore. I miss dad because I only see him two times a week.

Ric: Do you know why he doesn't live with you anymore?

JD: No! But I liked it when he lived with us; I used to see him everyday

Ric: Shall we talk about school now? What you like about school?

JD: Teachers think I am a good girl.

Ric: What other things do you like about school?

JD: I like some of the teachers and I like some of my friends.

Ric: Tell me some things that you don't like about school?

JD: I got bullied...I don't know why I got bullied but people punched and kicked me. My teacher Mrs B stopped it.

Ric: I am so sorry to hear that; it must have been awful for you. Do you still get bullied?

JD: Not really, not anymore

Ric: Do you know what happened when you were being bullied?

JD: No.

Ric: Did anyone try and help you?

JD: Yes Mrs B.

Ric: Apart from Mrs B did you talk to any adult about the problems you were having in school?

JD: Ah yes! I talked to someone, she was not a teacher, I can't remember her name but we did a play thing together!

Ric: Was it play therapy that you had?

JD: Ah yes! It was play therapy...I remember the woman's name now, it was 'H'.

Ric: What happened in play therapy?

JD: I talked to H. We made a book and decorated biscuits when it was my birthday. I also did some painting but I do know why I had to do play therapy.

Ric: What did you learn from play therapy?

JD: How to be nice.

Ric: Did you like play therapy?

JD: Yes.

Ric: And why was that?

JD: Because I just did, I liked spending time with H because we had lots of fun.

Ric: Anything else?

JD: I sometimes talked to H about being bullied and now I don't get bullied anymore

Ric: Did the play therapy help the bullying to stop?

JD: Maybe, I don't know

Ric: How do you feel having had play therapy?

JD: I am fine because I have two cats...because I have two cats and a dog.

Ric: Thank you very much for your time JD; is there anything else that you would like to tell me.

JD: No I can't think of anything else.

Ric: Do you know your way back to your classroom.

JD: Yes.

Ric: Okay then you better go to your classroom so you don't miss too much of the lesson. Bye bye and once again, thank you very much for your time and effort.

JD: Bye.